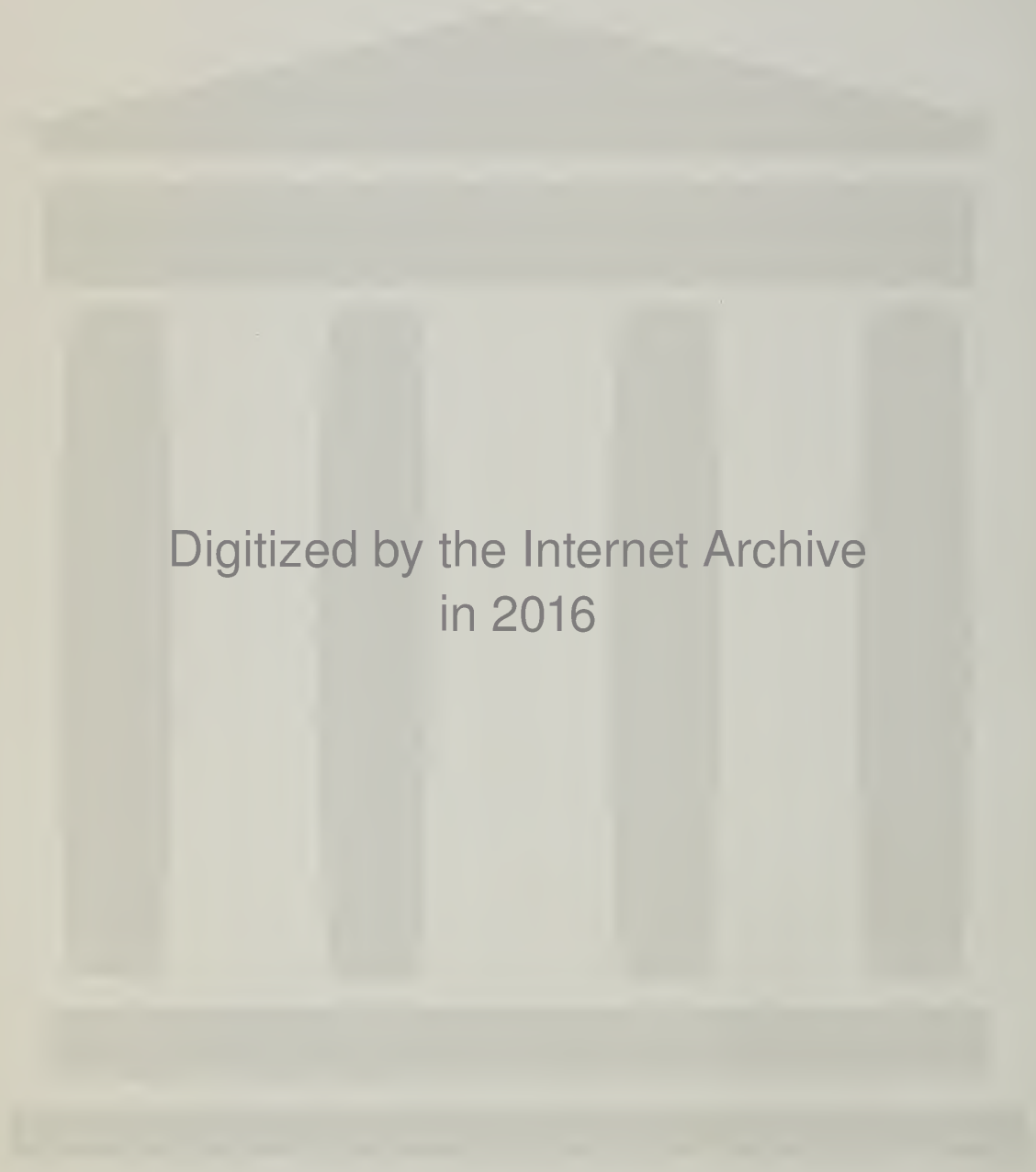
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VOLUME IX

January-December, 1968

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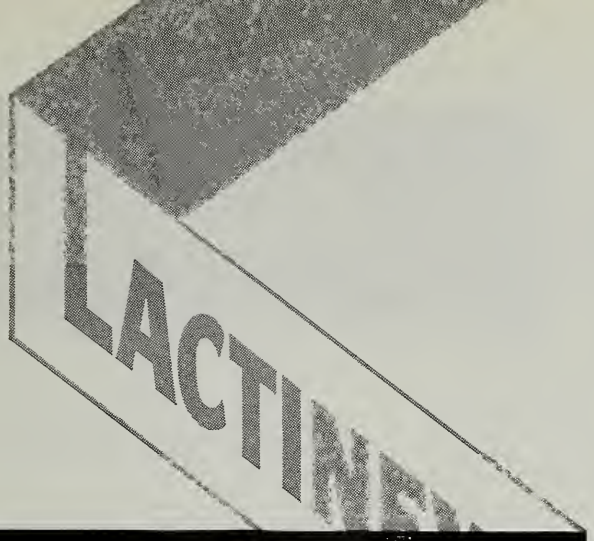
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No untoward side effects have been reported to date.

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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Drug Industry Carries Own Research Load

The prescription drug industry has announced that it financed more than 96 per cent of its research and development activities with its own capital last year. Government funds accounted for only 3.4 per cent of the industry's research.

By way of comparison with other industries, recent statistics show that government supports 90 per cent of the research and development in aircraft and missiles, 62 per cent for electrical equipment, and 27 per cent for motor vehicles. All private industry combined pays for only 41 per cent of its research and development with government supporting the remaining 59 per cent.

The massive 96 per cent paid by pharmaceutical firms is expected to be even higher this year, according to an annual survey released by the Pharmaceutical Manufacturers Association.

A record total of $476.2 million in R and D activity carried out or sponsored by the industry is predicted for 1968.

"This represents a 14.4 per cent increase over the $416.1 million allocated to such functions last year," noted PMA President C. Joseph Stetler, "which, in turn, was 14 per cent higher than the 1965 total."

PMA has consistently stressed high research costs, particularly during recent months when the industry has come under attack from certain congressional witnesses for so-called "high costs" of prescription drugs.

"Evidence of the industry's high research and development costs," said Stetler in announcing the survey results, "is the point made in this report that the average R and D costs of each new drug discovery since 1957 has been $6.8 million. Expenditures for new discoveries have been increasing at a rate more than twice as great as the increase in sales."

Stating that the odds are substantial against success in developing a drug product from new chemical materials, he said that for every useful one that is ultimately made available for health care, more than 6,000 compounds are studied and discarded. He explained that each year the drug industry tests more than 100,000 substances which "with costly development effort" yield only a relatively few completely new and marketable drugs.

The survey report revealed that $37 million was spent for research capital, plant and equipment investment last year, increasing the total value of such facilities to $273 million.

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Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (includ-

NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

January 1968

Dear Doctor:

The chiropractors are girding their loins for the biennial try for licensure in Mississippi, and they plan an all-out effort. In a December legislative meeting held at Jackson, the Mississippi Chiropractic Association called on all members of the Legislature to enact a licensure law. It is known that chiropractors have been unusually active in the recent political campaigns.

> Only Louisiana and Mississippi deny licensure to chiropractors and both are target states for 1968 legislative action. Drafts of bills circulated to date are same old proposals of "regulating chiropractic" and setting up licensure board of chiropractors.

Three hundred fifty Americans, mostly youngsters under age 10, will die this year in residential swimming pool accidents. The U.S. Public Health Service says that this tragic toll could be reduced by half with adequate poolside fencing, supervision of children while using pools, and proper water survival training.

Travelers Insurance Co., Mississippi's Part 1-B Medicare fiscal intermediary, is processing claims at a rate of more than 12,000 per month. Quarterly rate of claims payment to state physicians is now hitting about $1.8 million. Outlook for 1968 is 160,000 claims in a $6 million program. Fifteen insurance companies act as Part 1-B carrier in 28 states, paying out more than $250 million in physicians' claims during first operational year.

The biggest state medical society, New York, will vacate its mid-Manhattan offices and move to a new building at Lake Success on Long Island. The giant structure will contain 60,000 square feet and be built on 3.9 acres costing $4.44 per square foot for land alone. State society will pay cash with no assessment of its 28,000 members.

Handiest reference to come out in some time is "Immunization Information for International Travel," published by U.S. Public Health Service. The 120-page book gives immunization requirements for every nation in the world and costs only 40 cents from Government Printing Office, Washington. Since all immunizations except yellow fever may be obtained from private practitioners, book will be useful to physicians.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Alabama Has Physician Shortage, Medical Education Need

Montgomery - A special study by Booz, Allen, and Hamilton for the Alabama legislature reported that the state has an acute shortage of physicians with a nonmetropolitan ratio of 46.3 doctors per 100,000 or one physician for each 2,160, against one per 1,400 nationally. Report said that state should expand undergraduate and postgraduate medical education.

Hospital Costs Continue To Increase

New York - The cost of hospital services continues to outstrip all other health care costs with a 14.7 per cent increase over the past 12 months, 23.1 per cent since 1964, and 68 per cent on the 1959 baseline period. But physicians' fees, often blamed for high care costs, are up only 28.5 per cent since 1959, and prescription drugs are down 1.6 per cent in cost. Health Insurance Institute predicts that actual hospital costs will be $70 per patient day by 1970 and about $100 per day in 1975.

Famed Missionary Hospital May Close

Chicago - Reports from Lambarene, Gabon, say that the most famous missionary hospital in the world, that founded by the legendary Dr. Albert Schweitzer, may soon close for lack of funds. Dr. Schweitzer's successor, Dr. Walter Munz, has been in England on an unsuccessful fund-raising mission. Nearly $2 million is needed to complete modernization begun by Dr. Schweitzer in 1965, but only $14,000 has been raised. Hospital now has 6,000 admissions annually and 1,200 operations are performed in the non-air conditioned facility. Dr. Munz feels that Dr. Schweitzer's death took the glamor away from the institution.

Generic Antibiotics Flunk Efficacy Tests

Washington - Tests conducted on four competing and supposedly identical chloramphenicol capsules, three generic and Parke, Davis' Chloromycetin, showed that chemical similarity doesn't necessarily indicate therapeutic equivalency. Chloromycetin was 98 per cent dissolved in gastric juices after 30 minutes while generic competitors were as low as 20 per cent. Chloromycetin reached peak blood levels in one to two hours, while generics were four hours and of lower levels. Report on tests was made to Senate committee by Dr. Leslie M. Lueck of Detroit.

Good Samaritan Protection Given Ambulance Personnel

Albany, N.Y. - New York state has conferred the protection of its Good Samaritan law on ambulance personnel, including legally enrolled members of voluntary ambulance services. Previous to action, the law covered only physicians. Ambulance personnel must be adequately trained for job under New York law.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

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Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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Otolaryngology Leaflet Is Available

A new public information brochure, "What Is an Otolaryngologist?," promises to be the best answer yet to the layman's question, "An oto—what?" Published by the American Academy of Facial Plastic and Reconstructive Surgery, the four panel folder will be made available to physicians at cost.



New brochure explains otolaryngology to inquiring patients.

Apart from describing the otolaryngologist's sphere of professional interest and training background, the leaflet goes beyond mundane nosebleed and the ubiquitous T and A. In simple terms, tumor surgery, microsurgery of the ear, and plastic reconstructive procedures are discussed.

Announcement of the brochure came from Dr. Richard T. Farrior of Tampa, Fla., who is president of the academy. He said that quantities of the leaflet may be obtained from Dr. Jack R. Anderson, 1111 Tulane Ave., New Orleans, La. 70112.

AMA Sets Drug Abuse Conference

A two-day conference for physicians on the abuse of drugs by young people will be sponsored by the Council on Mental Health of the American Medical Association March 15 and 16 at the Drake Hotel in Chicago.

The program will include discussions of the causes of drug abuse, the treatment and rehabilitation of drug dependent persons, deterrents to drug abuse and latest research findings in the field. A highlight of the conference will be a panel presentation on medical management of those who abuse drugs and become dependent on them.

"Drug Abuse in the Now Generation" is the theme of the meeting, which will be the 14th annual conference held by the Council for members of state medical society mental health committees and representatives of state mental health departments.

WHAT DOES GALVANIC SKIN RESISTANCE DEMONSTRATE ABOUT THE EFFECT OF VALIUM (diazepam)?

Galvanic skin resistance... one measure of the Valium (diazepam) effect in reducing the somatic response to acute stress[1,2]

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Devised as a research tool in psychosomatic medicine, this interesting method records respiratory excursions, galvanic skin resistance, cardiac activity and finger pulse volume as physical responses to stress. These autonomic nervous system responses to a standardized stressor—a film dealing with life-threatening incidents—are continuously monitored on the polygraph.

This gives a graphic representation of changes which the body may undergo in reacting to stress. The application of modern statistical analysis to these graphs provides a yardstick by which the calming effect of Valium (diazepam) can be measured quantitatively.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with a history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See *Precautions.*)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

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References: 1. Selesnick, S. T., and Clemens, T. L.: From research film "Motion Picture Films in Psychosomatic Research," available from Roche Laboratories. 2. Clemens, T. L., and Selesnick, S. T.: *Dis. Nerv. System*, *28*:98, 1967.

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* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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Dr. Longino Heads UA Department

Dr. Luther Alvan Longino, pediatric surgeon from The Children's Hospital Medical Center in Boston, Massachusetts and the Harvard Medical School, has been appointed professor of surgery and head of the Division of Pediatric Surgery at the Medical College of Alabama. He will be responsible for the pediatric surgery programs at both University and The Children's Hospitals, Birmingham.

The appointment, effective Jan. 1, was announced by Dr. S. Richardson Hill, Jr., dean of the Medical College, and Dr. John W. Kirklin, professor and chairman, Department of Surgery.

Dr. Longino is currently senior associate in surgery at The Children's Hospital Medical Center, Boston, and assistant clinical professor of surgery at Harvard.

"We are fortunate in having a surgeon of Dr. Longino's stature and ability accept the chairmanship of the newly inaugurated Division of Pediatric Surgery within the Department of Surgery. His leadership will ensure the Medical Center's continued progress toward excellence in special surgical problems in infants and children," the joint statement said.

Dr. Longino earned his B.S. degree from the University of Arkansas in 1933 and his M.D. from Arkansas Medical School in 1935. Following an internship and a surgery residency at Charity Hospital in Shreveport, Louisiana, he was engaged in private practice in Magnolia, Arkansas, for seven years.

He joined the staff of The Children's Hospital Medical Center, Boston, in 1945, as voluntary graduate assistant in pathology. Subsequently, he served as house staff officer in surgery, 1946-47; assistant resident in surgery, 1947-48; and chief surgery resident, 1948-49. From 1949 to the present, he has served as surgeon, and since 1946, as senior associate in surgery, The Children's Hospital.

Dr. Longino joined the faculty at Harvard Medical School as instructor in surgery in 1949, and from 1965 to the present, he has been assistant clinical professor of surgery.

Dr. Longino serves on the Editorial and Advisory Board of the *Journal of Pediatric Surgery*. He is a Fellow of the American College of Surgeons, a diplomate of the American Board of Surgery, and holds memberships in numerous professional organizations.

Spring Vacation

at the

Holiday Inn—Rivermont

Memphis, Tennessee

Feb. 14, 15, 16, 1968

SEVENTY-NINTH ANNUAL MEETING

Mid-South Postgraduate Medical Assembly

THE LATEST ADVANCES IN MEDICINE BY DISTINGUISHED GUEST SPEAKERS:

G. E. Burch, M.D., Internal Medicine; Walter T. Hughes, M.D., Pediatrics; Edward Stainbrook, M.D., Psychiatry; Edward Adelson, M.D., Internal Medicine; Eugene Klatte, M.D., Radiology; Malcom E. Phelps, M.D., General Practice; W. King Engel, M.D., Neurology; Felix Rutledge, M.D., Obstetrics and Gynecology; Paul C. MacDonald, M.D., Obstetrics and Gynecology; Edward S. Judd, M.D., General Surgery; Jack C. Hughston, M.D., Orthopedic Surgery; Arthur S. Keats, M.D., Anesthesiology; Curtis P. Artz, M.D., General Surgery; Donald B. Effler, M.D., Thoracic Surgery; Victor A. Politano, M.D., Urology.

CLASS REUNIONS: Class of 1958—March, June, September, December; Class of 1953—March, June, September, December; Class of 1948—March, June, September, December; Class of 1943—March, June, September, December; Class of 1938—March, June, September, December; Class of 1933—March, June, September, December; Class of 1928; Class of 1923; Class of 1921.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
January 1968, Vol. IX, No. 1

ORIGINAL PAPERS

Complications of Abdominal Surgery

RICHARD F. RILEY, M.D.
Meridian, Mississippi

Deaths from complications following abdominal surgery are declining as a result of continuing advances in the knowledge of physiology, fluid and electrolyte requirements and control of infection as well as methods of preventing complications. The author discusses general complications following abdominal surgery and specific problems related to gastroduodenal surgery, colon surgery and appendectomy.

A DISCUSSION of the complications encountered in abdominal surgery would of course have to cover a tremendous amount of territory. I will therefore not try to cover all of the situations that one might encounter in surgical procedures on the digestive tract or in the abdomen. Instead I will limit the scope of this discussion to general complications that might follow any surgical procedure in the abdomen, then specific problems related to gastroduodenal surgery, colon surgery, and appendectomy as illustrative of some of the common complications encountered in abdominal surgery.

Pulmonary complications are probably the most common complications following abdominal surgery. Atelectasis is not as common now as it was when ether anesthesia was used. The reason for this is that the patient now awakens from anesthesia almost as the last stitch is being placed in the skin and begins to thrash about and cough and complain. A good reminder in handling atelectasis is to begin handling it days before surgery. If the patient has any symptoms of chronic pulmonary disease and is a heavy smoker, valuable time can be spent in preparing the patient one to two weeks prior to elective surgery. He should be instructed to stop smoking, given an expectorant and can be given instructions in deep breathing exercises.

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Endotracheal anesthesia is used in practically every case of abdominal surgery except appendectomy. The main weapon of the surgeon in the patient who can't cough should be the nasotracheal catheter which is inserted through the nose with the tongue being pulled out and intermittent application of suction into the trachea. A percutaneous introduction of a poly-ethylene intratracheal catheter can be used effectively also. An Intracath is effective for introducing this catheter. Through this can be introduced Muco-Mist or Varidase solution for liquefying secretions.

If the patient's pulmonary condition is such that one is concerned about the efficacy of any of these methods of clearing the tracheobronchial tree, a tracheostomy with insertion of a tracheostomy tube should be resorted to soon after surgery. We use IPPB in every abdominal case rou-

tinely. We use only saline to begin with and add Muco-Mist later if necessary. It is given every four hours the first 24 hours, then three to four times a day for two days following that.

The next most common complication is wound infection. The watchword here is prevention of contamination from an open abdominal viscus. We make it a point to pack off all exposed wound edges, to flush out the peritoneal cavity and the wound repeatedly if contamination occurs and this is even true in the so-called "prepared bowel." We routinely use a clean closure tray and change gloves with all open stomach, small bowel and large bowel cases. We use Iodophore solution for skin preparation. One must constantly keep in mind that the peritoneum is singularly resistent to infection whereas muscle and subcutaneous tissue and fascia are particularly susceptible to even the slightest contamination.

To avoid renal complications, take a history of past urinary tract disease and follow up as indicated with I.V.P., culture, concentraction test, etc. A B.U.N. is obtained in all patients over 45 or if history warrants at a younger age. We use the indwelling catheter a great deal and unfortunately we see a great deal of infection from these catheters. There are cases, however, in which we feel it is necessary to use the indwelling catheter. We do use routine irrigations of the catheter, and we also use a prophylactic sulfa drug if the patient is not on a broad spectrum antibiotic. A urine culture is always obtained when symptoms occur.

RECORD OF FLUIDS

We carefully record intake and output in all patients following abdominal surgery for 24 to 48 hours or longer if necessary. In patients in whom there is a question of possible renal compromise, we record the urine output at intervals of two to four hours. During surgery, we stress that the amount of fluid administered will produce a urine output of ½ to 1 cc. a minute and about the same on an average through the rest of the first post-operative day.

If the patient becomes oliguric during the first 24 hours, we first will push fluids. If this does not produce a diuresis, then the search for further cause for the oliguria is extended. We have been giving fluids up to 3,000 cc. as thus required the first day. We have also been giving colloid solution in the form of plasma or plasmanate to expand blood volume in patients who have had mild to moderate blood loss, not sufficient to require as much as 1,000 cc. of blood replacement. We have found this has reduced the amount of whole blood that is necessarily administered during anesthesia.

MEASURES AGAINST SHOCK

Another problem is shock. This encompasses three fields: fluid and electrolyte imbalance, blood loss, and endotoxin shock. If at all possible, rather than give blood in the operating room, blood is given the night before or the day before if needed. Then we wait until the patient is in the recovery room or after hemoglobin determination has been made about eight to ten hours after surgery before the transfusion is given. This, of course, is in the patient whose blood pressure and urine output is satisfactory.

Rather few of our gastrectomies have required transfusions during surgery. Gallbladder patients rarely require transfusions. The case most likely to require transfusion is the abdomino-perineal proctectomy for carcinoma or pancreatectomy. If the reason for gastric surgery is hemorrhage, of course the blood replacement requirement will have to be monitored but this is one of the few cases in which transfusion is required during surgery.

If actual shock is encountered in a patient in the immediate post-operative period, the first consideration should be blood replacement and the next is replacement of sequestered fluid. The present method of measuring central venous pressure in specific instances is the best indication of whether the patient is hypovolemic or not. The infusion fluid that we use most is lactated Ringer's solution or glucose in normal saline.

The fluid requirement as assessed for the average patient who is on nothing by mouth post-operatively is approximately 3,000 cc. per day. This is usually 2,000 cc. of electrolyte solution and 1,000 cc. of water. In patients with fistulas, the fluid lost is replaced volume for volume with an attempt to match the electrolyte composition of the material lost such as bile, duodenal contents or gastric contents. In fluid replacement, remember the shift of fluid which can occur into a traumatized area involving the abdominal wound and that the patient will require electrolyte solution in more quantities than you might think.

Urine output is your best guide to hydration and central venous pressure to tell effective circulating fluid volume. Potassium replacement in a patient receiving nothing by mouth should be begun parenterally within 24 hours after surgery

when it is certain that urine output is good and provided the patient has not required massive transfusions which would produce a hyper-kalemia from the the excess potassium in banked blood.

A word at this point about the use of steroid post-operatively: this is reserved for the treatment of patients recently treated with cortisone and for patients with gram negative bacteremic shock. In a patient who does not have a steroid deficiency, steroids do not help.

A common and usually innocuous complication, but a most aggravating symptom, is gastrointestinal atony and/or reflex ileus. The gastric atony is seen after vagotomy, and reflex ileus is seen after any type of gastrointestinal surgery. This is more pronounced in patients who are air swallowers and rather tense patients. I know of no method that will wholly prevent this condition.

The best method is to anticipate which cases are most likely to have reflex ileus or adynamic ileus and keep them on nasogastric suction for a longer time than is your usual routine. This will sometimes allow good bowel tone to be established and the passage of flatus is a little quicker than if the patient is allowed to become markedly distended. Once a well-established reflex ileus is present, the patient should again be placed on nothing by mouth, the nasogastric tube re-inserted and again administration of Prostigmin and colon lavages. The nasogastric suction and parenteral alimentation should be carried out for as long as necessary to establish good bowel tone and until the passage of flatus and stool is well established. This takes some perseverance and persistence and is nerve racking for both the surgeon and the patient.

CARDIOVASCULAR COMPLICATIONS

The next problem is cardiovascular complications. The subject of thrombophlebitis and pulmonary embolus is so extensive that I will give you just my opinion on this subject. When a suddenly swollen leg appears, we feel that the patient should have ligation or clip application to the vena cava and then femoral phlebotomy and aspiration of the thrombus as quickly as possible. If a person has a pulmonary embolus and the source of embolus is not immediately apparent, we rely on anticoagulants as the treatment of choice. We administer a large dose of heparin intravenously immediately and start Coumadin or Dicumarol. In our hands this has been successful and we have not had a fatal pulmonary embolus in an individual who has been anti-coagulated with the first sign of a small pulmonary embolus. I mention this because many people condemn this procedure stating that the second embolus may be the fatal one and the anti-coagulant will not remove the danger of a thrombus that is already present.

Coronary thrombosis is another complication that accurs in the post-operative period. Sudden development of shock, cyanosis, and respiratory difficulty, particularly in the recovery room, should make the physician suspicious of this condition. The usual routine for care of a coronary thrombosis is followed, and we rely upon our medical colleagues for this management.

TYPES OF ABDOMINAL SURGERY

Now let us turn our attention to selected specific areas of abdominal surgery. The first we will consider is gastroduodenal surgery. The most likely complications to be encountered following gastric resection are hemorrhage, rupture of the duodenal stump, and pancreatitis. We are firm advocates of the nasogastric tube before, during, and after gastric surgery. Occasionally we use temporary gastrostomy. Hemorrhage first will appear in the Levine tube in the recovery room. This normally will be a maroon or thick brown color and will quickly disappear.

If the drainage through the Levine tube continues to be thick bright red blood, the patient should be watched carefully. A rising pulse, a falling hematocrit and blood pressure and the usual signs of impending shock should be noted. The most common sources of bleeding in the gastrectomized patient is rebleeding from an ulcer left in situ or from the closed end of the stomach of a Hofmeister anastomosis. The latter can sometimes be stopped by irrigating the stomach with large quantities of iced saline solution. If the bleeding is brisk and the hematocrit if falling, the wisest course is to re-open the patient.

The way I manage bleeding from the cut end of the stomach is to take down the gastrojejunostomy and evert the suture line and place a continuous chromic catgut suture down the entire length of the suture line on the inside and then re-establish the gastrojejunostomy. We have a method of preventing this now which seems to be quite good and since we have been using it have not had any bleeding from this particular site.

The stomach is divided between a double row of clips applied with the von Petz clamp. The cut end of the stomach on the proximal side is then doubly closed with a running, locking No. 2-0

chromic catgut suture. No attempt is made to roll in the rows of clips with this particular suture and it is purely hemostatic. The next row is the inverting row using interrupted fine silk sutures. We also take great care to suture ligate the branches of the left gastric artery which approach the cut end of the stomach. Also as the stomach is opened and the duodenum is opened at anastomosis, great care is taken to clamp and ligate with fine, non-absorbable suture material, all the blood vessels in the musculo-serosal wall of the stomach and the duodenum as they are encountered.

The next complication of gastric surgery is leakage from the anastomosis or the duodenal stump. We have not had a known case of leakage of the anastomosis. We have had a few cases of obstruction of the anastomosis and non-functioning anastomosis which have had to be re-entered and revised. Why these stomas occasionally do not function is often a mystery because they will be patent at re-operation. The best advice is don't wait too long to re-operate.

Leakage from the duodenal stump is frequently a disaster and the best method of treating it is to carefully prevent it. We usually can recognize the duodenal stump which will give us this problem and of course we have all had difficulty handling a scarred duodenal stump. Many papers have been written with this title. The method of preventing this is to tailor the gastric operation to the patient's condition found at surgery. The gastric operation I prefer generally for duodenal ulcer is antrectomy and selective vagotomy and Bilroth I gastroduodenostomy.

CHOICE OF PROCEDURE

If the patient is being operated on for pyloric obstruction with a badly bound down duodenum or for previous perforation with a badly scarred duodenum or for intractable ulcer with a large posterior penetrating ulcer, we do not attempt to elevate the duodenum. In these cases we will do a pyloroplasty or a gastrojejunostomy. Of course, all of these procedures are accompanied by a vagotomy.

If I elect a Hofmeister anastomoses, the duodenal stump closure with an easy duodenum which I routinely employ is an inverting continuous chromic catgut layer and an outer reinforcing interrupted non-absorbable suture without tension on the suture line. An attempt is always made to bury the suture line against the pancreas or against a layer of peritoneum or fatty tissue much as one covers the bronchial stump. Care should be taken not to place a sump drain or Penrose drain against the suture line since this will lead to stump failure.

The following is a remarkable case in which the duodenal stump leaked and in which the patient survived.

The patient was a 58-year-old white male who entered the hospital with epigastric pain and nausea of four days' duration. The patient had had the same thing three years before admission. At that time an active duodenal ulcer had been diagnosed by x-ray and had been diagnosed again two months previously. His gastrointestinal series at the time of admission showed 85 per cent retention of barium after six hours with pyloric obstruction and an active pyloric channel ulcer. Surgery consisted of vagotomy, hemigastrectomy and anterior Hofmeister gastrojejunostomy.

CASE REPORT

His pathology consisted of the presence of two duodenal ulcers, one on the anterior duodenal wall and one penetrating into the pancreas. There was extensive scarring and the duodenum was closed in two layers. It was felt that the closure was secure, but as a precaution, a sump drain was placed down to the region of the duodenal stump closure and brought out through a stab wound in the right upper quadrant. The Levine tube was placed in the afferent loop.

On the fifth post-operative day the patient began to complain of right chest pain, and a chest x-ray revealed atelectasis of the lower lobe. For fear that the patient may have had a pulmonary embolus, he was heparinized. Eighteen hours later his blood pressure dropped to 0. Immediately a cutdown was done in the left ankle. Saline solution containing ½ gm. of Kantrex and a million units of penicillin was begun. Two hundred milligrams of Solu-Cortef was given intravenously. Levophed was administered. A peritoneal tap was performed and brownish fluid was obtained from the right upper quadrant and the left lower quadrant. A culture of this was E-Coli. An intraperitoneal polyethylene catheter was inserted percutaneously in the right upper quadrant and the right lower quadrant for instillation of kanamycin and penicillin. His blood pressure rose. He was given massive doses of Kantrex intravenously and intraperitoneally.

Twenty-four hours later or the ninth post-operative day he began to drain from the previously made stab wound in the right upper quadrant from which the sump drain had been removed one day prior to the development of these

symptoms. A duodenal fistula developed which closed in four weeks. This patient obviously had a gram negative septicemia secondary to generalized peritonitis produced by a disrupted duodenal stump. The secret of survival was the tract made by a sump drain.

The surgeon must not free too much duodenum for the closure (certainly not more than 2 cm. or the blood supply of the end of the duodenum will be compromised). Our routine for handling of the difficult duodenal stump is insertion of a 30 cc. No. 14 or 16 foley catheter in the end of the duodenum which is closed with a purse string and brought out through a stab wound in the right upper quadrant pulling the duodenum snug against the peritoneum creating a duodenostomy. In some cases we have had prolonged drainage of the duodenostomy, but we have not had to re-enter an abdomen to close this type of duodenostomy and it is safe and reliable. We have had minimal complications with this type of treatment of the duodenal stump. Pancreatitis is usually caused by ligating an accessory pancreatic duct during plication of ulcer of dissection of a bad duodenum. One must sometimes re-enter and remove the suture; another cause is from excessive trauma during dissection of a difficult duodenum.

LARGE INTESTINE COMPLICATIONS

Complications of surgery of the large intestine are indeed manifold. Surgery on this organ is one of the largest categories of operations of the general surgeon. Carcinoma of the colon is one of the most frequent malignancies in his practice. Surgical intervention for diverticulitis is becoming more widespread, and the older the population gets, the more colon surgery one seems to see.

Complications of colon surgery include wound infection and dehiscences, anastomotic leakages and disruptions, complications of colostomies, post-operative peritonitis and complications such as reflex ileus and pseudomembranous enterocolitis. Wound infection is a rather frequent complication following colon surgery, and we reiterate the necessity of carefully protecting the wound edges from contamination by the open bowel, frequent irrigations of the wound and the peritoneal cavity during the operation, and clean closure tray and gloves. We frequently drain the abdominal wall wound and also at the same time instill antibiotics through a wound catheter postoperatively if there is contamination.

Preparation of the bowel is imperative for successful anastomosis. We both cleanse the bowel mechanically and chemically with enemas and laxatives, both saline and castor oil, as well as using sterilizing drugs. Our drug of choice is Kantrex and if possible we will precede this with a three to four day course of Sulfasuxidine. When wound infection does occur, one must open the wound widely, that is the entire wound, down to the fascia. The wound should be packed open and re-packed frequently. We irrigate this wound with saline or saline containing Furacin solution.

DISRUPTED SURGICAL WOUNDS

Wound disruptions have occurred in a number of cases of colon surgery, perhaps because of the older age group requiring this type of surgery than in gastric surgery. This is usually in debilitated cases, cases that develop severe postoperative distention, patients with poor nutrition and patients that develop wound infection. We reclose these wounds with heavy non-absorbable near-and-far retention sutures. The two most common complications of large bowel surgery that we have encountered have been hemorrhage and anastomosis leakage.

We usually use either a transverse colostomy or a cecostomy tube in left colon anastomoses. We like the cecostomy for two reasons: It can decompress the colon and the nasogastric tube can be removed earlier and we also use it for continued instillation of Kantrex suspension, 1 gm. a day until the patient has bowel movements. Another valuable method for preventing suture line leakage in left colon anastomosis is paralysis of the anal sphincter tone by marked stretching of the anus at the termination of the procedure or actual sphincterotomy.

Pelvic abscess formation is often the result of anastomosis leakage. We believe in placing the anastomosis inside the peritoneal cavity and not beneath a peritoneal reflection if possible. If a low anastomosis is fashioned, all attempts should be made to bring the peritoneum down below the anastomosis. If the anastomosis is below the peritoneum, we drain the pre-sacral space.

ANASTOMOSIS LEAKAGE

If leakage of a colon anastomosis occurs, a proximal colostomy should be done. Leakage on the right side of the colon is far less than on the left, of course. It may even be necessary to do a proximal ileostomy (with its attendant difficulties) to manage a leakage from a right colon or transverse colon anastomosis leakage.

Complications following appendectomy are not as frequent as they used to be, but we will mention a few of them. One that we still see is wound

infection. We treat wound infection by wide opening of the wound. During the appendectomy, if the appendix has ruptured and peritonitis is present, attention should be directed toward looking around for a fecalith which might have spilled in the peritoneal cavity. If it can be found, a great deal of future trouble can be alleviated.

If a pelvic abscess forms postoperatively, the question that often arises is when to drain through the rectum. The answer is that if there is any doubt as to the fluctuance or where to drain it, then it should not be drained. The location and time to drain a pelvic abscess through the rectum is when it is a boggy bag of fluid about which there is no doubt and is bulging prominently into the rectum.

We attempt to prevent wound infections in appendectomies by packing off the edges of the wound with moist packs and changing them during the operative procedure as they are contaminated. Great care is exerted in preventing the infected appendix from touching the sides of the wound. The peritoneal cavity is irrigated with copious quantities of saline and again copious quantities of saline are used to irrigate the wound itself after the peritoneum is closed. The wound is drained and occasionally small catheters are placed in the wound for instillation of antibiotics.

The complications of peritonitis from perforated appendix are pelvic abscesses, sub-hepatic and sub-diaphragmatic abscesses. In cases of peritonitis from perforated appendix, we lavage the peritoneal cavity with 3,000 to 4,000 cc. of saline. Percutaneous poly-ethylene catheters are placed in the peritoneal cavity for instillation of antibiotics. We instill either Kantrex or Chloromycetin. Drains are placed in the right lower quadrant and brought out through the wound itself or stab wounds.

Fecal fistulas still occasionally develop after appendectomy and they are treated by low residue diet, antibiotics and sterilization of the bowel contents. The drainage will usually stop rather suddenly on about the 10th day. Other complications following an appendectomy are thrombophlebitis and atelectasis but these have already been mentioned.

Deaths from complications following abdominal surgery are definitely declining, and it speaks well for continuing improvement in our knowledge of physiology, fluid and electrolyte requirement and control of infection, as well as our continuing search for methods of preventing complications.

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CONGENITAL ANOMALIES

The curious seven year old boy asked his mother, "How was I born?"

"The doctor brought you in his little black bag," she replied.

"Well, how were you born?" he queried further.

"Why, my mother found me under a cabbage in the garden," the mother explained.

"And how was Grandmother born?" continued the curious boy.

"Oh, she was brought by a long-legged bird called a stork."

At school the next day, the boy told his science teacher: "Mrs. Brown, do you know that there hasn't been a normal delivery in our family in three generations!"

Compression of the Spinal Cord By Metastatic Tumors

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METASTATIC TUMORS involving the spinal cord are being reported with increasing frequency as the cancer patient's longevity is enhanced by surgery, antibiotics, irradiation, and chemotherapy. These neoplasms continue, however, to escape early detection and treatment, and as a result many of the patients are completely paraplegic at the time of surgical decompression. The present report reviews our experience with metastatic neoplasms implicating the spinal cord or nerve roots treated during the past five years at the University Medical Center. It was hoped that some of the factors bearing on the diagnosis, treatment, and prognosis of these tumors would be more clearly defined by such a review. A more exhaustive analysis of all neoplasms of the spinal cord will be reported at a future date.

In-patient charts were reviewed of all patients undergoing decompressive laminectomy for histologically confirmed metastatic neoplasms between the years 1961 and 1966. The time interval was noted between the patients' symptoms of spinal cord involvement and his admission to the University Hospital for operative decompression. The various patients' first symptoms were recorded and the interval determined between the onset of paraplegia and laminectomy. Results of spinal fluid protein determinations, Queckenstedt test, plain spine x-rays, and myelography were noted. Other areas of inquiry dealt with operative findings, pathologic diagnosis, evidence of a primary neoplasm, postoperative survival and the degree of neurologic function regained postoperatively.

Forty-two charts were reviewed. The average age of the patients was 57.7 years with a range of 13 to 80 years. There were 11 females and 31 males, 21 Caucasians and 21 Negroes, 13 private patients and 29 house service patients. The time interval from the patient's first symptom referable to spinal cord involvement to admission to the University Medical Center was on the average 4.4 months. Twenty-three of the 42 patients or 55 per cent of the total were paraplegic with no useful motor function of the lower extremities at the time of operative decompression.

The average duration of their paraplegia was 13 days prior to the time of decompression.

Spinal cord compression secondary to metastatic neoplasms is increasing in frequency. This report reviews the experience with metastatic neoplasms implicating the spinal cord or nerve roots treated during the past five years at the University Medical Center. The early signs and symptoms of spinal cord involvement are cited, along with the diagnostic aids.

There were only minor differences between persons of variable socio-economic status and persons of different races in the average duration of paraplegia or other symptoms prior to operation. There were only 8 patients whose paraplegia had been complete for less than three days. The onset of the patient's symptoms leading to neurologic impairment was thought to be acute, that is, complete within 48 hours of onset of symptoms, in only 7 of the 42 patients, or 17 per cent. Thus, the great majority of these patients had a gradual onset and progression of symptoms.

Pain was the initial symptom in 51 per cent of the patients. It was localized over the involved area of the spine in 14 per cent, was bandlike in the chest in 17 per cent, and "sciatica" or pain in the lower extremities was experienced by an-

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other 16 per cent. Four per cent of the patients complained of pain in the neck or upper extremities. Other initial symptoms were distributed as follows: weakness of the legs, 29 per cent; paresthesias, 11 per cent; sphincter loss, 3 per cent; and ataxia or difficulty in walking, 6 per cent.

Plain x-rays of the spine were normal in only 15 per cent of the patients. Pedicle erosion alone was noted in 33 per cent of the patients. Localized bone destruction occurred in 33 per cent and collapse or fracture of vertebrae in another 15 per cent, many of whom also had pedicle erosion. Miscellaneous other changes occurred in 4 per cent of the patients.

Of those patients who had spinal fluid studies, 10 had proteins of less than 100 mg. per cent and 16 over 100 mg. per cent. The Queckenstedt test was blocked or partially blocked in all but one of the patients whose protein was over 100 mg. per cent and only in one of the 10 patients whose protein was less than 100 mg. per cent.

Twenty-eight patients (67 per cent) had complete block of the dye column at myelography, 10 patients (24 per cent) showed filling defects, and four patients did not have preoperative myelograms. The "brush border" extradural block as seen in Figure 1 was typical for the metastatic lesions. This contrasts markedly with the usual primary intradural central nervous system tumors which tend to show the characteristic widening or displacement of the spinal cord shadow as seen in Figure 2.

The pathologic diagnoses are shown graphically in Figure 3. Seventy-two per cent of the patients had other signs of metastatic disease at the time of admission to the University Hospital. This included x-ray evidence of a neoplasm elsewhere, the history of previous neoplasm, or evidence of metastatic disease noted on physical examination.

Survival time and degree of postoperative neurological impairment were ascertained in 69 per cent of the cases. The average survival of the patients who have already died was 5.9 months. Those who died of metastatic carcinoma with a



Figure 1. Myelogram showing extradural block in the pantopaque column at T-1, T-2 level. Tumor calcification and destruction of the spinous process at T-1 are also evident.



Figure 2. Myelogram showing intradural extramedullary type of block with displacement of the spinal cord shadow to the left by a neurofibroma. A "meniscus" outlines the inferior border of the tumor.

primary neoplasm in the lung lived on the average less than three months postoperatively, those with prostatic neoplasms lived over five months, those with lymphomas more than eight months and those with myelomas over one year. Patients who were not paraplegic at the time of decompression survived on the average for seven months; those who were paraplegic survived only for 2.3 months.

Twenty of the 23 paraplegic patients remained so postoperatively; only three showed some improvement in motor function, one of these becoming ambulatory. Most patients, however, obtained some pain relief, had some return of sensory function postoperatively, and were able to retain some sphincter control. Of the 19 patients who were not paraplegic at the time of operation, 10 had no further progression of their neurologic disease during their period of postoperative follow-up, but did not regain any additional motor function. Eight patients had slight to moderate improvement in their motor deficit postoperatively, and one patient lost some additional motor function following decompression.

CLINICAL COURSE

In this group of patients, the clinical course was highly suggestive of metastatic disease for many weeks prior to operation in most cases. Nevertheless, in our experience, patients with metastatic spinal cord compression progress more rapidly with few exceptions than do patients with primary central nervous system neoplasms.

The overall results of surgical decompression in our patients with metastatic neoplasms, as expected, were not encouraging as far as survival and improvement in motor deficit were concerned. On the other hand, an occasional patient with metastatic spinal cord involvement survived three to four years after operation with preservation of neurologic function of the lower extremities and sphincters. Good palliative results were obtained in many cases even in face of negligible return of motor function. To the patient who is paraplegic, intact sphincters and normal sensory function are important in preventing decubitus ulcers and the pain relief obtained through decompression to many patients was well worth the minimal risk of the operative procedure.

Generally speaking, in patients with metastatic disease of the spine showing evidence of a primary lesion in the lung, survival could be measured in terms of weeks. Patients with multiple myeloma, lymphoma, and carcinoma of the prostate survived for longer periods with less neurological impairment. The course of the many patients who were completely paraplegic preoperatively was dismal indeed. Only one patient regained the ability to walk. Because of the extended period of paraplegia, it is probable that secondary infarction of the spinal cord had taken

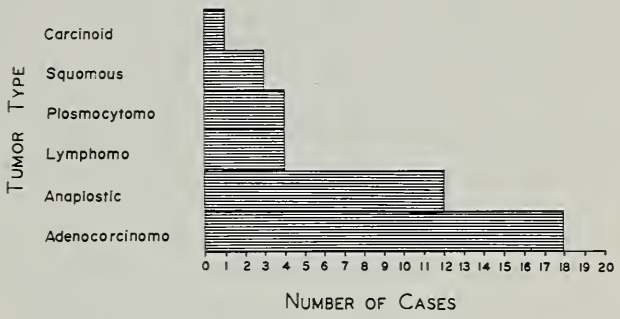


Figure 3. Distribution of pathologic diagnoses.

place in many patients. Experimental compression studies[1] indicate that once paraplegia is complete, only a few hours remain in which decompression, if to be of significant benefit, must be accomplished. Earlier decompression in some of these patients, before they were paraplegic, might have extended their useful life for several months.

The reason for the delay in arriving at a definitive diagnosis was not always apparent. The local spine pain and the radiating chest or extremity pain was misinterpreted in many instances. Two patients with lower thoracic tumors without neurologic deficit underwent laparotomy because of persistent abdominal pain. Several patients who complained of low back pain and sciatica were treated with pelvic traction, and two patients were operated for lumbar disc who eventually were found to harbor lumbar tumors. The Guillain-Barre syndrome was mimicked in several instances by ascending motor weakness and elevated spinal fluid protein in the absence of a cellular response of the spinal fluid. Radicular chest pains, present in 17 per cent of our cases, were particularly misleading and were often suggestive of heart or lung pathology. In some cases, a patient with known malignancy ignored a progressive neurological impairment in the lower extremity until he was essentially paraplegic attributing the weakness to general debilitation. Occasionally only the pain of a markedly distended bladder forced some patients into seeking medical advice.

DIAGNOSTIC TECHNICS

Excluding the symptoms and signs of spinal cord compression, plain x-rays of the spine and myelography were most consistently helpful in

leading to an early diagnosis. A neoplasm could be suspected from the plain x-rays of the spine taken at the appropriate level in 81 per cent of our cases. In contrast, few patients with primary central nervous system neoplasms show bony changes on plain x-rays. All of the patients who underwent myelography showed either a filling defect or a complete block in the dye column. The myelogram was by no means free from false negative results however. At least three patients had undergone earlier myelography with the lesion being overlooked on the first study. In each of these cases, the myelograms were reviewed and showed that the dye column had not been carried to the appropriate level to show the neoplasms.

It has been our policy to decompress immediately any patient who shows a block in the dye column at myelography. The tumor, in most instances, extends over only 2-3 segments and has been managed by posterior laminectomy and wide extradural decompression. Catheters are routinely threaded along the extradural space to assure adequate decompression and removal of any additional compressing tumor mass or collapsed bone. If the mass is extradural, the dura mater is not routinely opened as this structure provides an effective barrier against tumor invasion of the spinal cord itself. Needless to say, care of the skin, bladder, and lungs is of paramount importance in the immediate postoperative state. In patients who obtained only partial relief from decompression, or if the tumor was radiosensitive such as is the case with the lymphomas or with multiple myeloma, cobalt therapy was routinely given.

ARRESTING DETERIORATION

This series would support the view that decompressive laminectomy, if performed before the patient is paraplegic, may arrest further neurologic deterioration and provide good pain palliation. After total paraplegia, the operative procedure is less effective, perhaps due to the vascular changes associated with the expanding mass. Patients with lymphomas, myeloma, and carcinoma of the prostate seem to derive more benefit from decompression than those patients whose tumors arise in the lung. Myelography provides invaluable information as to the tumor type and location but should be delayed until immediately prior to decompression, as disturbances in spinal fluid dynamics distal to a tumor occasionally produce neurological deterioration. In acute paraplegia, emergency decompression must be performed (within a few hours of onset) if any useful return of function is to be expected. Prevention of paraplegia, besides the symptomatic relief that it produces, renders the patient a much smaller burden to nursing facilities and families who must care for them.

SUMMARY

Spinal cord compression secondary to metastatic neoplasms is increasing in frequency. Emergency decompression, before the patient becomes paraplegic, provides good palliative results in patients with carcinoma of the prostate, multiple myeloma, and lymphomas. The results in patients whose tumors arise in the lungs are poor, and the values of surgery are less well defined in this group. ★★★

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RED, WHITE, AND WHAT?

After the medical meeting in Philadelphia had adjourned, the visiting physician decided to see some of the historic sites in the nation's cradle of liberty. Seeking directions, he asked a police officer, "Could you please tell me where Betsy Ross' house is?"

Leaning closely to the doctor, the policeman confided, "Listen, friend, this new city council has closed all of those places."

Post-Exertional Myoglobinuria: A Case Report

THURMAN T. JUSTICE, JR., M.D.
Gulfport, Mississippi

Judging from the literature, myoglobinuria may be more common than is recognized. The author reports a case of post-exertional myoglobinuria with deficient lactic acid response to ischemic exercise. He reviews the literature pertinent to muscle phosphorylase deficiency.

MYOGLOBINURIA MAY be more common than is generally recognized judging by the increased number of cases reported since Bowden *et al.*[2] reviewed 25 cases published prior to 1956. Twelve of these seem to have been related to exercise. They reported three additional cases. Wheby and Miller[14] reviewed 49 cases and reported two cases in 1960.

Perusal of the National Library of Medicine *Indexus Medicus,* 1960 to 1967, revealed reports of at least 30 additional cases of myoglobinuria; 15 of these seem to have been exercise related and all except three were males.[3, 4, 6, 7, 9, 10, 11, 13] An additional 28 refrences, which were not reviewed, were noted.

That myoglobinuria may follow traumatic muscle injury and/or arterial occlusion is common knowledge. Vigorous muscle exercise may produce myoglobinuria. Indeed, the "squat-jump exercise" cases reported by Howensteine[6] are reminiscent of the post-exertional myoglobinuria seen in horses. This may also be true of some postictal cases.

Myoglobinuria has been related to licorice ingestion and/or hypokalemia, alcoholic episodes, infectious disease,[2] and trichinosis. A group remains for which no etiology is known.[4]

The case reported here is thought to represent a type of post-exertional myoglobinuria due to deficiency of muscle phosphorylase and having its onset relatively late in life. Similar cases have been reported.[3]

All instances of post-exertional myoglobinuria surely do not fall into this group. There may be no regularly producible post-exertional recurrence in cases of other types following exercise.[6, 7]

From the North Medical Service, Memorial Hospital at Gulfport.
Read before the Gulf Coast Academy of Medicine, May 4, 1967.

This 39-year-old fireman was seen in January 1967 complaining of the passage of dark urine associated with chilliness and fever and occurring after heavy physical exercise. He related that he had been aware of this difficulty, perhaps to a lesser degree, for probably a year. He related episodes where he had helped his brother to lift, where he had ridden a bicycle vigorously and where he had used a hammer for nailing.

After these episodes, the muscles involved would become hard, swollen, and tender. On the occasion of lifting there was marked pain in the back muscles preventing him from sleeping. Following the use of the hammer, the muscles of the upper arm became swollen and tender, and this arm was markedly larger than the opposite member.

He had not noted symptoms following walking or lesser exertions or less sustained exertions such as feeding his cattle from a truck on occasion. He had noted symptoms on occasion following pulling a hose in conjunction with his work as a fireman.

After the physical activity, aside from the soreness and stiffness of the muscles, he would become chilly and have fever some four hours and be aware of passage of dark urine several times.

No knowledge of similar situations in other members of the family could be elicited. His

father died at age 45 of an accident. His mother is living at age 62. A sister age 44 is living and well, and a brother died at age 14 following a ruptured appendix. He is of French extraction. He had been on no medication. There was history of hay fever in the spring and probably asthma during childhood.

Questioning revealed that there was no childhood history of any difficulty or weakness and he played football and volley ball and other sports and participated in vigorous exercises, apparently without difficulty until the present history.

Physical examination revealed a well-muscled male of about the stated age. He was seen after an episode of marked exertion of the right thigh and these muscles were firmer, hard, as compared with the opposite member although only one centimeter difference in diameter could be measured. Inspiratory and expiratory wheezes were scattered over the chest. No abnormalities of peripheral vessels and no abnormal reflex changes were elicited.

Blood count was normal with a normal white count and differential. Admission urinalysis was normal. Direct Coombs test was negative. BUN, serum protein and A/G ratio, postprandial blood sugar, alkaline phosphatase and bilirubin and VDRL were normal or negative.

The day following admission the serum lactic dehydrogenase was elevated to 1,300 units, and elevation of the serum transaminase (GOT) was 262 units. Thymol turbidity was normal. Prothrombin time was normal. A day later the LDH had diminished to 608 units and the GOT to 157 units. BSP revealed 2.8 per cent retention in 45 minutes. Cephalin flocculation was normal. A chest x-ray was normal as was a cholecystogram. The electrocardiogram was normal.

TIGHTNESS AND FATIGUE TEST

Subsequently the patient was exercised by having him walk up and down five flights of stairs until he began to note tightness and fatigue in the thigh muscles. Several hours later he began to pass dark amber to blackish colored urine and testing this revealed positive tests for blood and protein. Microscopic studies revealed no red cells. Immunoassay of the urine revealed a level of 6.4 mg. per liter of myoglobin against a normal value of 1.6 mg. per liter.

Several days later he was submitted to an ischemic exercise test as described by Schmid and Mahler.[12] The attending physican served as a control and samples were drawn for determination of lactic acid resting, 2, 4, 6, 8, and 10 minutes after the exercise. Results of this test are plotted in Figure 1.

It was planned to have both the subject and the control exercise under the same condition for a period of 45 seconds. Subject was unable to complete this because of pain and contracture of the muscles of his forearm. He was unable to completely extend the middle fingers of this hand for several days and the arm was markedly swollen and painful for at least three days following this exercise.

METHOD OF BLONDHEIM

Blondheim *et al.* described methods for distinquishing myoglobinuria.[1] Three ml. of 3 per cent sulfosalicylic acid is added to 1 ml. of urine and filtered or centrifuged. This would remove any protein pigment (myo or hemoglobin) present and leave the fluid (supernatant or filtrate) and normal urine color. This would exclude porphyria, dyes, alcaptonuria, melanuria, bile and indoles. Then to five ml. of urine is added 2.8 gm. of ammonium sulfate, and the material is again filtered or centrifuged. This will precipitate hemoglobin but not myoglobin leaving the abnormally-colored filtrate or centrifugate in myoglobinuria.

Further identification would be dependent upon electrophoretic, spectroscopic, and/or immunologic method. An immunologic method was used here and is reported to be sensitive to as little as 0.8 mg. of myoglobin per liter.[15]

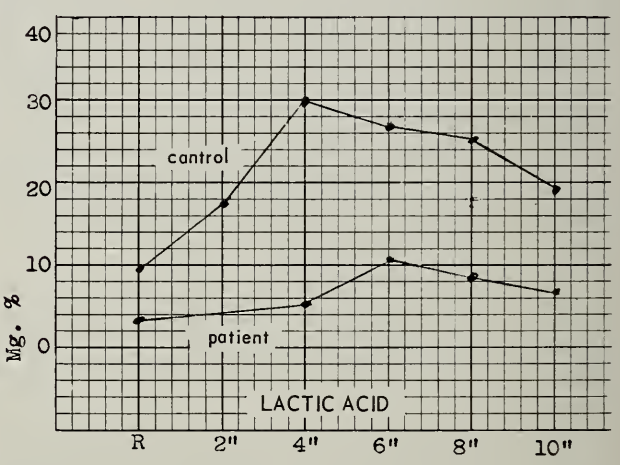


Figure 1

In the above case the ammonium sulfate method was equivocal and is apparently not as sensitive, nor possibly as specific, as the immunologic method. It would appear that the strenuousness

of the exercise as well as the size of the muscle groups involved is related to the amount of myoglobinuria.

Additional findings consistent with muscle injury were the elevations of SGOT and LDH in the presence of a normal electrocardiogram, normal serum bilirubin, and normal liver function tests.

It is interesting that when this man confronted physicians on several previous occasions with a specimen of his dark urine, he was told that he had kidney trouble. Confusion with acute nephritis has been noted.[6]

In this case and similar cases reported, the muscle pain and soreness following exertion is characteristic and the patient notes dark urine. This may be relatively transient, may vary in degree with relation to the exercise as it probably did in this case, and may not be considered significant by all patients. The information concerning dark urine may therefore not be volunteered. Myoglobinuria may be suspected when confronted with this history, a positive test for urine protein and a positive benzedine test.

LABORATORY TESTS

The presence of only a few red cells in the urine sediment would add further support. Separation of serum revealing a normal color would further suggest that the material in the urine responsible for these positive tests was myoglobin since this material is not bound (by haptoglobins) as is hemoglobin and visually high serum levels are not found.

One may generally be criticized for using provocative tests as aids to diagnosis. In myoglobinuria, death due to acute tubular necrosis has been reported. However, in this case and in many others reported, this means of accurately ascertaining the diagnosis has been used without mishap. Here use of larger muscle groups (stair climbing) produced gross myoglobinuria whereas more strenuous, prolongedly painful, exercise of forearm muscles did not. Also being able to accurately advise an individual of the permanent hazard of future arduous exertion may be of distinct value, since no therapy is available. Increasing blood glucose by use of Glucagon and a high carbohydrate regime has been advocated by some but the actual usefulness is dubious.

This situation would appear to be familial and transmitted by a single, recessive, autosomal gene.[13, 16]

In 1951 McArdle[8] described a 30-year-old male with exertional muscle cramping. He demonstrated by means of an ischemic exercise test that there was no rise in lactic acid in veinous blood from the exercised member and postulated a defect in muscle glycogen breakdown. Myoglobinuria was not mentioned in this report.

POST-EXERTIONAL CASE

Schmid and Mahler[13] in 1959 reported the case of a 52-year-old male who had cramping and muscle weakness after exercise for 30 years and who passed dark brown urine following episodes of exertion sufficient to cause symptoms. Myoglobinuria and failure of lactate and pyruvate rise after exercise was demonstrated. They also found a high glycogen content in the patient's muscle tissue (2.4 to 3 per cent weight), and absence of phosphorylase activity in muscle homogenate Additional study of members of the same family revealed other cases and suggested the hereditary nature of nature phosphorylase absence.

Pearson, *et al.*[9] described, in an also thorough study, a 19-year-old male who could not make the transition from light to moderate or strenuous muscular work because of muscle pain and cramping. This patient probably had episodes of myoglobinuria, but this was not confirmed. Plasma lactate did not rise during ischemic exercise. Stainable muscle glycogen was increased. The authors speculate that the nature of glycogen synthesis for storage must be by an alternate pathway, which may be only anabolic, and which is dependent on uridine diphosphate glycogen transferase bypassing the phosphorylase and the branching enzyme systems.

Rowland, *et al.*[10] report a case of a 31-year-old male afflicted for "as long as he could remember" in the manner previously related and including myoglobinuria. Enzyme assay of muscle biopsy disclosed almost complete absence of phosphorylase and normal or increased enzymatic activity for uridine diphosphate glycogen transglucosylase, uridine diphosphate pyrophosphorylase, phosphorylase kinase, phosphorylase phosphatase, amylo-1, 6-glucosidase and phosphoglucomutase. Muscle glycogen was increased 5 fold. The ischemic exercise test revealed no lactic acid rise. Liver phosphorylase normalcy was indicated by normal response to epinephrine and glucagon.

DISEASE CLASSIFICATION

Thus this abnormality is in actuality a glycogen storage disease.[9, 10] The following classification has been proposed:[10]

Demonstration of the area of defect of enzy-

TYPE	EPONYM	TISSUES	GLYCOGEN	ENZYME DEFECT
1. Hepato-renal	vonGierke	liver kidney	normal	glucose-6-phosphotase
2. cardiac	Pompe	general-ized	normal	amylo-1.4-glucosidase?
3. limit dextrinosis	Cori Forbe	liver, heart muscle	short outer branches	debrancher (amylo-1,6-) glucosidase
4. amylpectin-osis	Andersen	liver lymphoid	few branches	brancher?
5. muscle	di Santagnese	muscle	normal	??
6. phosphoryl-ase	Hers	liver	normal	hepatic
	McArdle	muscle	normal	muscle

Figure 2

matic activity in the above listed glycogen storage disorders is diagramed below and the enzymes are numbered and listed.[16]

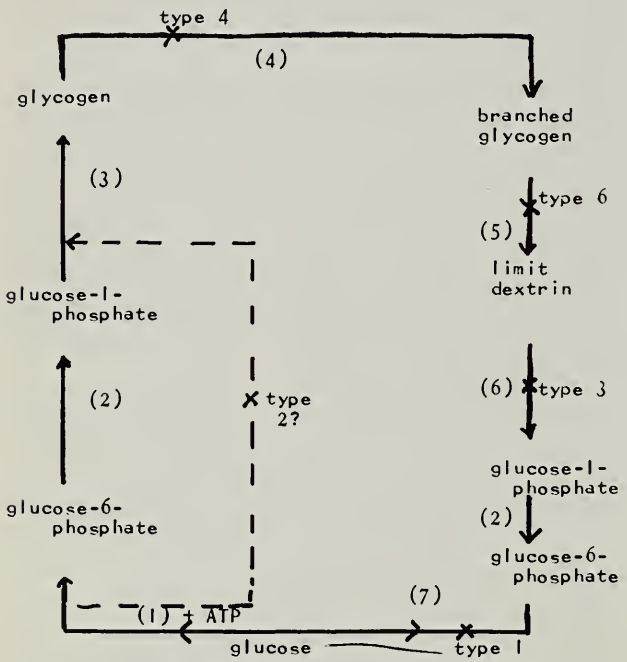


Figure 3 (modified from Field 16)

In Engel's two cases,[3] one demonstrated failure of lactate to rise but a rise was found in the second case and the histo-chemical enzyme studies were compatible with absence and normal phosphorylase values respectively. Other techniques were stated to reveal a phosphorylase deficiency (35 per cent normal). Myoglobinuria could not be demonstrated in either. This is somewhat at variance with other cases reported.

In the present case there was slight lactate rise but at maximum this was 3 fold less than the control. The lactic acid determination done in this case utilized a technique and reagents supplied by Sigma Chemical Company (St. Louis, Mo.). The onset of symptoms was late. The average age of onset in 84 per cent of the exertional group as reported by Korein[7] was 18 ± 2.8 years. In the non-exertional cases the onset was 5.3 ± 2.3 years. One wonders whether or not the age of onset may correlate with severity in the exertional cases.

From the descriptions contained and the clinical information concerning patients whose disorder would seem to be best documented, it could be concluded, in agreement with Rowland,[11] that although muscle pain can probably occur in other patients with glucolytic disorders, contracture of the exercised muscle is an outstanding feature and has been noted above. In addition to this, a history of myoglobinuria would seem to strengthen the suspicion of a phosphorylase deficiency. A history from other members of the family is useful. Demonstration of failure of rise of veinous lactate, although degree is variable in normal individuals, would seem to further substantiate the diagnosis.

SUMMARY

A case of post-exertional myoglobinuria with deficient lactic acid response to ischemic exercise has been reported. A basis for clinical suspicion and laboratory confirmation of myoglobinuria is presented. Some of the literature pertinent to muscle phosphorylase deficiency is reviewed. These cases are glycogen storage disorders.

Post-exertional muscle contracture, myoglobinuria, other similarly afflicted relatives, and failure of veinous lactate rise in a member exercised ischemically seem valid criteria for diagnosis of McArdle's disease. ★★★

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NEONATAL NEMESIS

A woman with a baby in her arms boarded a train. When the conductor came to her seat to take her ticket, he exclaimed, "My, what an ugly baby. I have never seen an uglier one!"

The mother was deeply upset, and she told him that she was reporting his affront to his superiors.

Arriving at her destination, she sought out the station agent and told him that she wanted to file a written report of misconduct on the conductor.

"Certainly, madam. Just complete this brief form setting out the details of your complaint." Handing her the form and a pencil, he said, "Here, let me hold the monkey for you."

Radiologic Seminar LXIX: Spontaneous Pneumothorax

OTTIS G. BALL, M.D.
Jackson, Mississippi

THE TERM PNEUMOTHORAX was coined by Itard in 1803 to define a collection of air in the pleural cavity with resulting collapse of the lung.

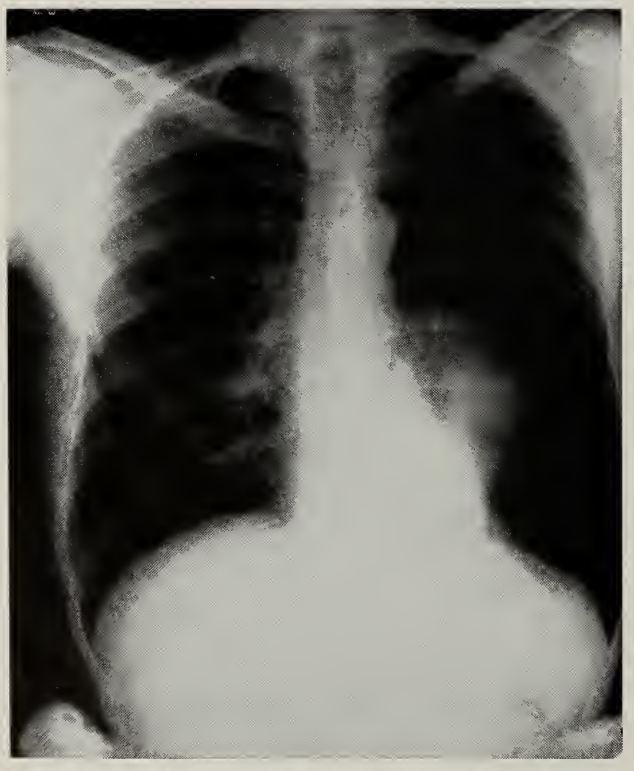
For many years it was the opinion of most that the cause of pneumothorax was a ruptured subpleural focus of tuberculosis. However, today it is recognized that the great majority of pneumothoraces are secondary to rupture of emphysematous blebs or bullae. These are usually located in the apical or posterior segment of the upper lobe.

Spontaneous pneumothorax is most common between the ages of 20 and 40 years and is much more frequent in men than in women. There appears to be no significant association with strenuous activity or recent pulmonary infections. The right and left lungs are about equally affected.

Symptoms vary greatly in severity but usually consist of pain, cough, and dyspnea. In the case of tension pneumothorax, the signs and symptoms are more marked and cyanosis, hypotension, and shock may be manifested.

The frequency of recurrence is reported as varying from 5 per cent to 50 per cent in different series. Bilateral pneumothorax is reported as occurring in about 10 per cent of patients, though simultaneous bilateral pneumothorax is fortunately extremely rare.

Usually, there is no generalized bronchial or pulmonary disease (See Figure 1), though spon-



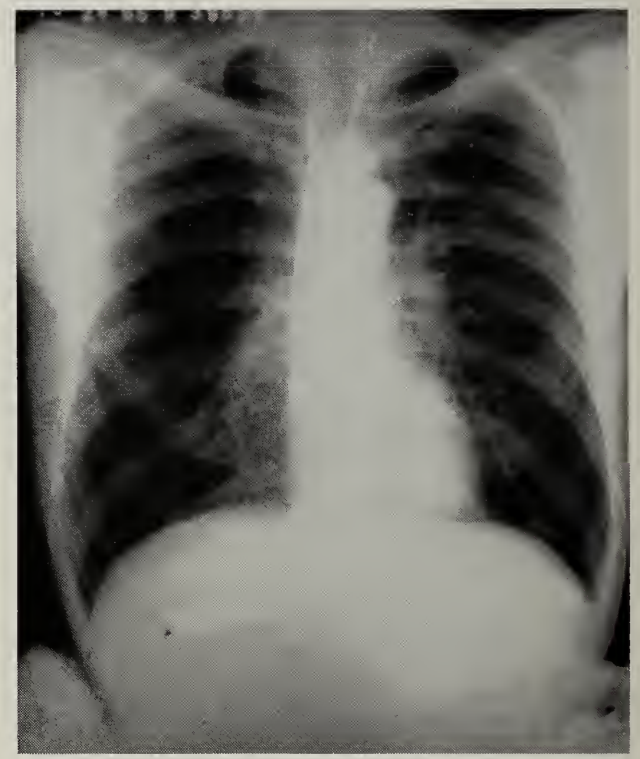


Figure 1. A. Forty-five year old male with pneumothorax on the left with nearly complete collapse of the left lung. B. Film four days later shows complete re-expansion of the left lung with no radiographic evidence of parenchymal or pleural disease.

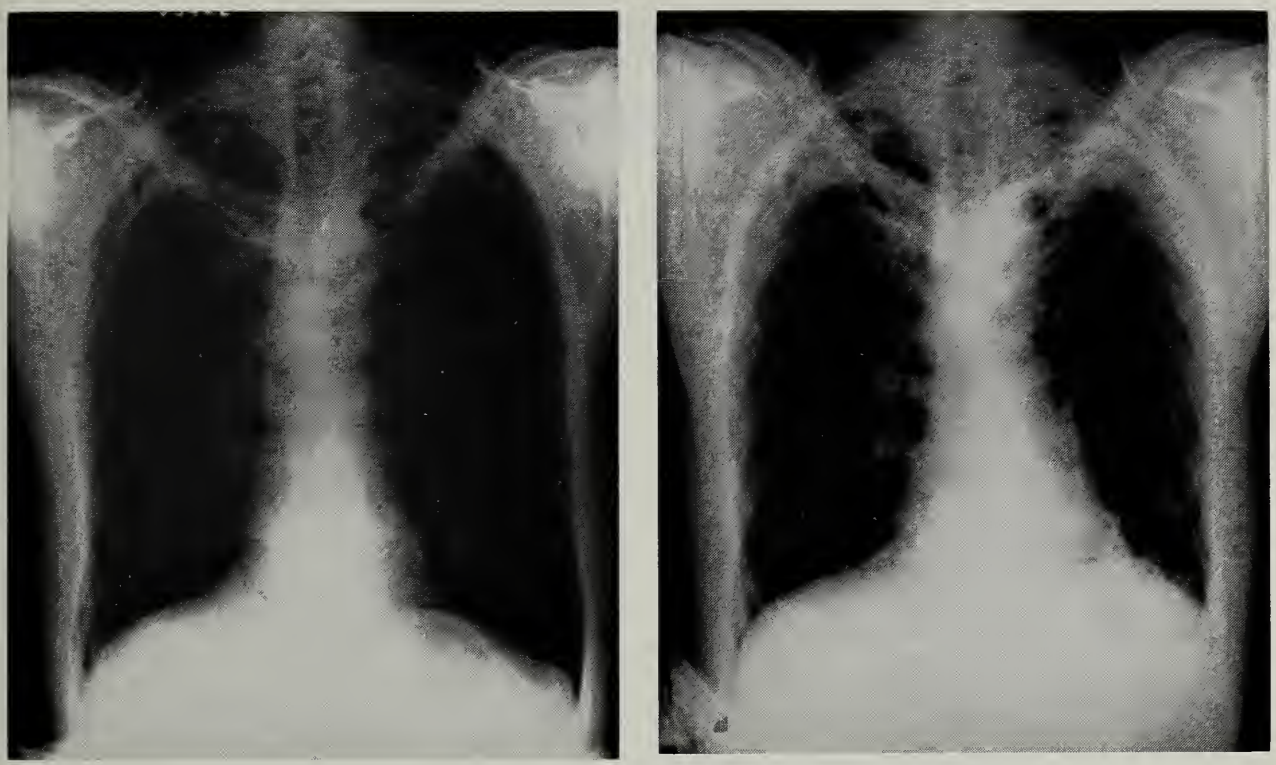


Figure 2. A. Forty-seven year old male with pneumothorax on the left with an approximate 60 per cent collapse of the left lung. B. Film six days later reveals complete re-expansion of the left lung. Large bullae are noted in each apical segment of the lung with generalized emphysema and fibrosis.

taneous pneumothorax may be associated with almost any pulmonary disorder. Lynn reported the following as the most common: bullous emphysema, asthma, cor pulmonale, pulmonary tuberculosis, miscellaneous (See Figure 2).

The complications of this disorder vary with the type of treatment instituted. The most commonly encountered ones are pleural effusion (if severe, it may produce a great deal of pleural thickening), infection, hemorrhage, atelectasis, and recurrence.

The radiographic diagnosis of spontaneous pneumothorax is usually fairly straightforward. The outline of the collapsed lung is usually clearly defined by the dense strips of visceral pleural and no lung markings are observed peripheral to it. A small or large pleural fluid level may be present. A small pneumothorax may be overlooked, especially if the film is viewed without a history of suspicion. Films should be obtained in full inspiration and expiration in all suspected cases. Apical lordotic films are sometimes helpful to demonstrate a small apical collapse. Very rarely, differentiation between a localized pneumothorax and a large bulla or cavity becomes difficult. An element of tension is demonstrated by displacement of the heart and mediastinal structure toward the contralateral side.

The management of pneumothorax has varied greatly over the years and some feel that over all it is still one of the most frequently neglected and poorly managed of the more commonly seen chest disorders. This is particularly true if one follows the cases in regard to long-term care as recurrence, morbidity, length of hospitalization, and pulmonary complications are concerned. Many feel that closed thoracostomy with water-seal suction drainage should be used for all cases with more than minimal collapse. Moreover, earlier thoracostomy with corrective surgery directed toward the diseased segment of lung is now advocated. The definitive treatment generally consists of wedge resection of the blebs combined with pleural scarification. ★★★

1151 N. State St. (39201)

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MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 16-20, 1968, San Francisco, Calif.; Clinical Convention, Dec. 1-4, 1968, Miami Beach, Fla. F. J. L. Blasingame, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

American Academy of General Practice, Annual Meeting, Sept. 13-20, 1968, Las Vegas, Nev. Mr. Mac F. Cahal, Executive Director, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

Southern Medical Association, Annual Meeting, Nov. 18-21, 1968, New Orleans, La. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 100th Annual Session, May 13-16, 1968, Jackson. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. S. E. Field, Jr., Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. William O. Barnett, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, First Monday January and July, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Robert L. Forman, Coahoma County Hospital, Clarksdale, Secretary.

Coast Counties Medical Society, First or Second Wednesday, January, March, May, September, and November. C. Hal Cleveland, 3017-13th St., Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday Quarterly, Jefferson Davis Memorial Hospital, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday March, June, September, and December. A. Derrick, Jr., Durant, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December, Corinth. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Oxford. M. Beckett Howorth, Jr., 2200 S. Lamar Blvd., Oxford, Secretary.

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South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, Green Clinic, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Patrick G. McLain, 1301 Washington St., Vicksburg, Secretary.

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C. Ralph Daniel, Jr., Jackson, Medicine (1970)
John E. Lindley, Meridian, Ob-Gyn (1968)
J. Purvis McLaurin, Jr., Oxford, Ob-Gyn (1969)
Charles P. Tharp, Tupelo, Pediatrics (1968)
Wm. F. Sistrunk, Jackson, Pediatrics (1970)
Rhea L. Wyatt, Holly Springs, Preventive Medicine (1968)
Frank J. Morgan, Jr., Jackson, Preventive Medicine (1969)
Raymond S. Martin, Jr., Jackson, Surgery (1968)
Carl D. Brannan, Jackson, Surgery (1970)



The President Speaking

'Drug Abuse'

TEMPLE AINSWORTH, M.D.
Jackson, Mississippi

THE EXPLOSION OF HEADLINES about drug abuse has aimed a flurry of questions at physicians from anxious parents, worried patients, educators, public officials, and just about everybody who has swallowed an aspirin tablet. It is perfectly true that drugs are abused, and the extent to which this abuse occurs today is greater than ever before simply because there are more people to abuse more drugs.

Two years ago, the Congress was moved to enact the Drug Abuse Control Amendments of 1965, nominally aimed at the barbiturates and amphetamines but since extended to many other drugs. It is in this law that we got the refill-five-times or six-months expiration of prescriptions, and it also placed stringent controls on pharmacists as to recordskeeping. But the sensational aspect of drug abuse is found in the furor over the hallucinogenic agents employed for thrill, curiosity, and by ritual of the cult of "mind-expanders."

What has perhaps disturbed the medical profession more than anything else about all of this is the incidence of drug abuse by young people, especially college students. Our American Medical Association has given us a useful tool with which to communicate the senseless danger of drug abuse in the 25 page booklet, "The Crutch That Cripples: Drug Dependence." It is written lucidly and in colorful language readily understood by parents or the younger people, and it covers most aspects of drug abuse including dependence, abuse of narcotics, sedatives, stimulants, and hallucinogens.

The booklet can be invaluable to the practicing physician in communicating medical information to patients, both as a record of the communication and a time-saving device. The booklet may be purchased from AMA for 25 cents per copy and for as little as 17 cents in quantities of 1,000 or more. Its availability also suggests a useful public service project for local medical societies. Let's make use of it in curbing this danger. ★★★

JOURNAL OF THE
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EDITORIALS

The Toll of the Presidency: A Shorter Life

I

THE PRESIDENCY OF THE UNITED STATES was described by its 26th occupant, William Howard Taft, as "the loneliest place in the world." And as many other Presidents have been moved to speak of the loneliness of the office, historians, journalists, and White House-watchers are in near-universal agreement that the job is the toughest, most demanding, and burdensome office attainable.

The Presidency has outlasted the thrones of emperors, kings, sultans, and czars to become the principal pinnacle of world power. That it has exacted a toll upon the lives of 32 of its 35 occupants—36 for those who haggle over Grover Cleveland's second term after Benjamin Harrison's succeeding him at the conclusion of his first—is now a matter of hard mortality data. The effect is perhaps not as profound as it might be, since our Presidents come mainly from the more favored segments of American society, and they are vigorous men, tenacious of life. Ambition, drive, and enthusiasm must motivate any man who aspires to that post from which more power is wielded than has ever been held by an hereditary or constitutional monarch.

There are 32 deceased Presidents, so the study begins with the concession that their lifespans cannot be considered a substantial data pool on mortality and its relationship to occupational endeavor. Nonetheless, the mean duration of their lives after taking the office has been less than might have reasonably been expected from mortality conditions prevailing at the time of their respective inaugurations. Moreover, any proposition that the Presidency attracts men of similar types or dispositions which might conceivably be associated with a shorter lifespan is thoroughly confounded by the varied backgrounds and styles of those whom the republic has chosen.

The contemporary historian, Richard H. Rovere, has compared the man-killing office to the practice of medicine; he writes: "Most of the time of most men in most periods of history has been occupied with supporting and maintaining life—preventing the worst from coming to pass. There is mystery and majesty in the Presidency because there is mystery in life and majesty in great human societies. Politics is a healing art, and in the American society the President is the principal physician and the only general practitioner. He diagnoses and prescribes. He must design splints for social fractures. His decisions and his words may be stimulants or tranquilizers, coagulants or anticoagulants. His first mission is to keep the patient alive, whole, and ambulatory."

II

A recent study by the actuaries of the Metropolitan Life Insurance Co. on the lifespans of American Presidents states that some light is shed on the question by comparing Presidential longevity with that of the Vice Presidents and unsuccessful candidates for the office of President. From John Adams, the first Vice President,

through Hubert Horatio Humphrey, there have been 38 Vice Presidents of the United States. And since 1789 when George Washington took office, there are 40 deceased unsuccessful candidates who received some electoral votes.

The 28 deceased Presidents who died natural deaths as opposed to the four who have been assassinated by gunfire lived a mean lifespan of 70.7 years or about three-tenths of a year longer than the mean life of 24 deceased Vice Presidents, excluding that "whisky-drinking, poker-playing, evil old man," John Nance Garner who almost became a centenarian. The 28 Presidents also lived about six-tenths of a year longer than their 40 unsuccessful political adversaries. Here, the comparison must be limited, because four of the 32 deceased Presidents have been struck down by assassins, while no Vice President or unsuccessful candidate for the office has ever been murdered.

But in the context of mortality circumstances in their respective times, report the Metropolitan actuaries, these 28 Presidents lived about 1.5 years less than they should have. Even so, they fared better than the deceased Vice Presidents who fell short of their life expectations by 2.6 years and the unsuccessful candidates who missed by 2.2 years.

Where the picture darkens is with the inclusion of the four assassinated Presidents. Then, the mean lifespan drops to 68.5 years, approximately 3.6 years below their life expectation at the time of their respective inaugurations. The pre-Civil War Presidents, Washington through Buchanan, lived an average of 74.2 years each. From Lincoln through John F. Kennedy, the deceased Presidents lived an average of only 63.4 years each. The last hundred years has been more demanding in terms of toll of life in the White House, because this is about 10 years less, the actuaries tell us, than these Presidents should have lived.

The longevity records are held by John Adams and Herbert Hoover whose terms were separated by more than a century and a quarter. Both lived to become 90 years of age. The shortest-lived Presidents were James A. Garfield who died at 49 and John F. Kennedy, at 46, both at the hands of assassins.

III

The eagle on the Great Seal of the United States holds a businesslike bunch of arrows in his left claw and an olive branch in the right, but his head is facing the sign of peace. This is fair enough when related to the Presidency, because 10 of the 35 have been generals. They were Washington, Jackson, William Henry Harrison, Taylor, Pierce, Grant, Hayes, Garfield, Benjamin Harrison, and the contemporary Dwight Eisenhower. A number saw military service in lesser grades, such as the 20th century's Teddy Roosevelt, a colonel of cavalry; John F. Kennedy, a naval lieutenant; and Lyndon B. Johnson, a naval lieutenant commander.

The generals were hardy souls, as might be expected of career military men, and except for the three who died in office, William Henry Harrison, Zachary Taylor, and James A. Garfield, their longevity record is good.

For those intrigued by coincidence or the occult and baffling aspects of Presidential lives, the last century seems to demonstrate a sort of curse on certain residents at 1600 Pennsylvania Avenue. For 100 years from Lincoln through Kennedy, each President elected or re-elected at 20 year intervals has died in office, including four by assassins' bullets. They are Lincoln, 1860; Garfield, 1880; McKinley, 1900; Harding, 1920; Franklin D. Roosevelt, 1940; and John F. Kennedy, 1960. It is said by some of the Kennedy biographers that he was aware of this curious fact of history.

Even the first President to die in office, William Henry Harrison, was elected in 1840, but the arithmetic continuity was broken before Lincoln's



"Doctor, it's about this post-nasal drip. . . ."

death when Taylor died in the White House after having been elected in 1848.

IV

This little exercise in mortality statistics relating to some of the world's most powerful and prominent individuals can hardly be expected to illuminate the literature on how long we live under what circumstances. But for the scientist, the student of history, and those who simply want to know a little more about the men and times in the course of their nation's development, the facts are interesting and absorbing.

And it is clear that the mean lifespan of the last 19 American Presidents is down 10 years from that of the first 15 during a period when medicine has advanced more than at any other time in history. By contrast, the mean lifespan of the Vice President is getting longer.

John Adams said that "had I chosen President again, I am certain I could not have lived another year." At Lincoln's inauguration, James Buchanan told him, "If you are as happy, my dear sir, on entering this house as I am in leaving it and returning home, you are the happiest man in the country."

Herbert Hoover put it this way: "Many years ago I concluded that a few hair shirts were part of the mental wardrobe of every man. The President differs only from other men in that he has a more extensive wardrobe."

But Lincoln said it best of all: "I feel like the man who was tarred and feathered and ridden out of town on a rail. To the man who asked him how he liked it, he said: 'If it wasn't for the honor of the thing, I'd rather walk.' "—R.B.K.

Updating the Ethics of Professional Courtesy

Of all of medicine's great and lasting traditions, none is more universally practiced nor hoary with years than that of professional courtesy. Since Hippocrates, physicians have cared for one another and the immediate dependents of their colleagues with no expectation of compensation. But, says the Judicial Council of the American Medical Association, keeper of the profession's ethics, times are changing, and many physicans are raising pertinent and proper questions about professional courtesy.

These are some of the questions which the Judicial Council has considered:

—What about the psychiatrist rendering long-term care to another physician or member of his immediate family, giving two hours a week from his restricted time?

—What about the obstetrician in the university community who has almost all the faculty and medical student wives for patients, a significant percentage of his total practice?

—What about the ophthalmologist who may be called upon to fit contact lenses for members of a physician's entire family?

—If the recipient of the care has health insurance, is it proper for the physician rendering the care to accept the benefit payment?

Bombarded by these questions, the Judicial Council has pointed out that the custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share as well as their mutual concern to apply their learning for the benefit of one another as patients. In offering this definition, the Judicial Council reaffirmed and endorsed the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

The council went on to say that professional courtesy is *not* a rule of conduct which is to be enforced under threat of penalty of any sort. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and to what extent he shall allow a discount from his usual and customary fees for the professional services he renders and to whom he shall render such services without charge as professional courtesy.

The Judicial Council suggests four guiding principles to aid physicians in resolving the questions which have arisen:

—Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

—Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

—In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time or in cases of long-term treatment, fees may be charged on an adjusted basis so as

not to impose an unreasonable burden upon the physician rendering services.

—Professional courtesy should always be extended without qualification to the physician in financial hardship and to members of his immediate family who are dependent upon him.

The pronouncement is sound, making good sense in terms of reaffirming and preserving tradition while realistically recognizing that things today perhaps are not exactly as Hippocrates found them.—R.B.K.

Alcohol and Home Accidents: Duo of Danger

There's no place like home, especially to get hurt or killed. Every year, about 8,300 individuals in their prime years, ages 15 through 64, are killed at home, and a whopping 8.5 million sustain nonfatal injuries. Worse yet, it has been discovered that alcohol plays a significant role in many of these deaths and injuries.

Although a vast majority of drinking Americans do so without subjecting themselves to any appreciable accident hazard, there is evidence aplenty to demonstrate that injudicious use of alcohol can and does result in tragedy around the home. Consider, for example a study of about 850 home fatalities which occurred in 1965. Of these 14 per cent of the male deaths and 20 per cent of female deaths were directly associated with drinking.

Of about 60 home fatalities due to poisoning from ingestion of solids or liquids, half were linked to drinking. In three-fourths of the cases, a drug which was potentiated by booze figured into the picture. In about a fifth of the deaths related to inhalation of poisonous vapors or gas, alcohol was a factor. Many victims died inhaling carbon monoxide while sitting in automobiles with the engine running, sleeping or resting from drinking.

Falls on steps accounted for about 100 home accidents, and one out of five was drinking. A few fell from roofs or windows under the influence.

In a fourth of deaths from home fires, victims had apparently fallen asleep after drinking while smoking. Alcohol was implicated in one out of seven home firearms accidents, in about a fifth of drownings, and in all deaths from freezing at home.

Home accidents are generally caused by environmental hazards in combination with human fault. These include poor design or layout, poor housekeeping, inadequate maintenance of appliances, and weather factors. Less tangible factors such as personal health, attitudes, habits, fatigue, and emotional tension also play a role. Home is dangerous enough without magnifying these everyday hazards with excessive drinking.—R.B.K.

A Belated Welcome to Louisiana M.D.'s

Mississippi is known throughout the nation as the Hospitality State, and it is a source of high satisfaction that more and more visitors come into her borders each year. Not the least among our welcome guests are convention groups from other states, including national, regional, and even state conventions who find Mississippi a nice place to meet.

Especially welcome are our colleagues in medicine, and in this connection, another first may have been scored in a pre-Christmas meeting on the Mississippi Gulf Coast. The Jefferson Parish Medical Society—and that's a Louisiana *county* society, it should be emphasized—chose to conduct its first annual clinical assembly at the Broadwater Beach Hotel.

From press reports, a splendid program was offered with essayists from the Louisiana State University School of Medicine. Officers of the society at the time of the meeting were Dr. John



"Whale the tar out of him, and put him to bed without his supper."

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Tanner, president, and Dr. Israel Fisher, president-elect.

This editorial expression is a belated welcome to our Louisiana colleagues, and we hope that they will return again to sample Mississippi hospitality. And while we're about it, we also commend our meeting facilities and warm welcome to our medical friends in Memphis, Tuscaloosa, Mobile, Pensacola, and New Orleans, too.—R.B.K.

POSTGRADUATE CALENDAR

OTOLARYNGOLOGY IN GENERAL MEDICAL PRACTICE

University Medical Center, Jackson
January 5, 1968, beginning at 8:30 a.m.

Sponsored by the University of Mississippi School of Medicine postgraduate education committee and the Department of Surgery, Division of Otolaryngology.

Friday Morning

WELCOME
Robert Carter, M.D., dean and director

WHAT'S NEW IN EXTERNAL OTITIS?
Edley Jones, M.D., consultant in surgery (otolaryngology)

ANTRAL WINDOWS IN THE TREATMENT OF SINUS DISEASE
Howard Cheek, M.D., clinical instructor in surgery (otolaryngology)

THE PROBLEMS OF THE LUMP IN THE NECK
Myron Lockey, M.D., clinical instructor in surgery (otolaryngology)

REHABILITATION OF THE LARYNGECTOMEE
Ralph Frybarger, M.A., clinical instructor in surgery (communication disorders)

CHRONIC OTITIS MEDIA
Ralph Sneed, M.D., clinical assistant professor of surgery (otolaryngology)

OTOSCLEROSIS AND ITS SURGERY
Chester Masterson, M.D., clinical instructor in surgery (otolaryngology)

TYMPANOPLASTY
Tom Louis III, M.D., clinical instructor in surgery (otorhinolaryngology)

Friday Afternoon

NASAL PHYSIOLOGY AND PATHOLOGY
Eugene Hesdorffer, M.D., clinical assistant professor of surgery (otolaryngology)

WHAT TO DO WITH THE HOARSE PATIENT
Robert Snider, M.D., chief resident in surgery (otolaryngology)

ELECTRONYSTAGMOGRAPHY
Norman Martin, M.D., resident in surgery (otolaryngology)

HEARING TESTS IN CHILDREN
M. O. Malphurs, M.Ed., instructor in surgery (otolaryngology) and chief of audiology, communication disorders clinic

TONSIL PROBLEMS IN PEDIATRIC OTOLARYNGOLOGY
J. L. Holcomb, M.D., resident in surgery (otolaryngology)

FILM: "CANCER OF THE CERVICAL ESOPHAGUS"
Godfrey Arnold, M.D., professor of surgery, chief of the division of otolaryngology and assistant professor of physiology

SEMINAR IN ALIMENTARY TRACT PROBLEMS

University Medical Center, Jackson
January 25, 1968, beginning at 8:55 a.m.

Sponsored by the University of Mississippi School of Medicine postgraduate education committee and the Department of Medicine

Thursday Morning

FUNCTIONAL GASTROINTESTINAL PROBLEMS
Psychiatric Considerations
Joseph Roberts, M.D., assistant professor of psychiatry
Radiologic Aspects
Robert Sloan, M.D., professor of radiology and department chairman
Medical Approach
Samuel Stephenson, M.D., clinical assistant professor of medicine

POSTGASTRECTOMY PROBLEMS
Medical Approach
Leonard Posey, M.D., clinical associate professor of medicine
Radiologic Aspects
Ottis Ball, M.D., Department of Radiology, Mississippi Baptist Hospital
Surgical Considerations
James Hardy, M.D., professor of surgery and department chairman

Thursday Afternoon

Colitis—Ulcerative, Granulomatous and Amoebic
- Medical Management
 - Lidio Mora, M.D., clinical associate professor of medicine (part-time) and director of the division of gastroenterology
- Radiologic Considerations
 - Hugh McLeod, M.D., instructor in radiology
- Surgical Management
 - William O. Barnett, M.D., professor of surgery

Current Status of Carcinoma of the Colon
- Radiologic Aspects
 - W. Melvin Flowers, M.D., assistant professor of radiology
- Surgical Considerations
 - George Gillespie, M.D., clinical assistant professor of surgery
- Chemotherapy
 - Gordon Deraps, M.D., instructor in medicine and director of the clinical cancer training program

UNIVERSITY MEDICAL CENTER DAY

University Medical Center, Jackson
February 1, 1968

Sponsored by the University of Mississippi School of Medicine postgraduate education committee

Thursday Morning

Patient Selection in Chronic Hemodialysis
- John Bower, M.D., assistant professor of medicine and director, artificial kidney unit, University Medical Center

Current Status of Mississippi Regional Medical Programs
- Guy Campbell, M.D., director, Regional Medical Programs, and clinical associate professor of medicine, University Medical Center

Diabetes Mellitus in Infants and Children
- Jose Montalvo, M.D., assistant professor of pediatrics, University Medical Center

Postgraduate Medical Education
- Joseph Roberts, M.D., assistant professor of psychiatry, University Medical Center

Advances in the Management of Choriocarcinoma
- John W. Choate, M.D., assistant professor of obstetrics-gynecology, University Medical Center

Management of Coronary Artery Disease
- Patrick H. Lehan, M.D., associate professor of medicine, University Medical Center

Thursday Afternoon

Obesity
- Guy F. Hollifield, M.D., professor of medicine, Northwestern University Medical School, Chicago, Illinois

CIRCUIT COURSES

Southern Circuit
- Biloxi—January 3, January 10, January 17, Howard Memorial Hospital, 6:30 p.m.
- Hattiesburg—January 4, January 11, January 18, Forrest General Hospital, 6:30 p.m.
 - Session 1—Early Recognition and Management of Skeletal Abnormalities in Infants and Children
 - Radiologic Approach, Dr. Lloyd Berrong
 - Orthopedic Considerations, Dr. Paul Derian
 - Session 2—Modern Practices in the Management of Tuberculosis
 - Surgical Aspects, Dr. William A. Neely
 - Medical Aspects, Dr. Guy Campbell
 - Session 3—Renal Trauma
 - Management of Traumatic Renal Shutdown, Dr. John Bower
 - Surgical Aspect of Urinary Tract Trauma, Dr. Lamar Weems

Eastern Circuit
- Columbus—January 23, Aubrey and Ellon's Restaurant, 6:30 p.m.
 - Session 1—Burns
 - Management of the Acute Burn, Dr. William A. Neely
 - Plastic Procedures in Reconstruction, Dr. Heber Ethridge

FUTURE CALENDAR

January 3, 10, 17
Circuit Course, Biloxi

January 4, 11, 18
Circuit Course, Hattiesburg

January 5
Otolaryngology in General Medical Practice

January 23
Circuit Course, Columbus

January 25
Alimentary Tract Problems



February 1
UMC Day

February 15
Neurology Seminar (Diseases of Children)

February 20
Circuit Course, Natchez

February 27
Circuit Course, Columbus

March 1
Renal Disease Seminar

March 5
Circuit Course, Meridian

March 14-15
Religion and Medicine

March 27-29
Cardiovascular Seminar

April 1-2
American Board of Surgery

April 2
Circuit Course, Meridian

April 11
Diabetes Seminar

April 16
Circuit Course, Natchez

April 18
Thoracic Society

April 23
Circuit Course, Columbus

May 7
Circuit Course, Meridian

May 13-16
Mississippi State Medical Association

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

Batson, Paul James, Jr., Batesville. Born Memphis, Tenn., February 2, 1923; M.D. University of Tennessee, Memphis, Tenn., 1951; interned Baptist Memorial Hospital, Memphis, Tenn., one

year; residency St. Joseph Hospital, Memphis, Tenn.; elected November 28, 1967, by North Mississippi Medical Society.

WOOD, WILLIAM LUCIAN, JR., Tupelo. Born Memphis, Tenn., August 17, 1938; M.D. University of Tennessee, Memphis, Tenn., 1962; interned St. Thomas Hospital, Nashville, Tenn., one year; residency St. Thomas Hospital, Nashville, Tenn., two years (internal medicine), University of Iowa, one year (internal medicine), Iowa City, Iowa; elected October 30, 1967, by Northeast Mississippi Medical Society.

DEATHS

MASSENGILL, ROBERT CAMERON, Brookhaven. M.D., Tulane University, New Orleans, La., 1932; interned Newell Sanatorium, Chattanooga, Tenn.; died Nov. 4, 1967, aged 59.

MAY, WILLIAM ROSS, Brookhaven. M.D., Tulane University, New Orleans, La., 1921; interned St. Vincent's Hospital and Baptist Hospital, Birmingham, Ala.; Touro Infirmary, New Orleans, La.; retired April 1967; died November 13, 1967, aged 70.

SUBER, ROBERT LEE, Pascagoula. M.D., University of Tennessee, Memphis, Tenn., 1956; interned McLeod Infirmary, Florence, S. C.; died Nov. 7, 1967, aged 35.

Syntex Establishes Speaker Service

A nationwide speaker service has been inaugurated by Syntex Laboratories as a special service to medical and community organizations. Speakers are available to state and county medical groups for their programs or to accept speaking engagements arranged by these organizations or their members.

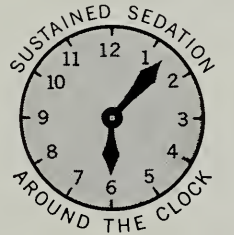
The speakers have been selected from field managerial personnel. The subject of their first program is the population explosion, which President Johnson has called "humanity's greatest challenge . . . second only to the search for peace." "Two's Company, Three Billion's a Crowd," comments on how a world which cannot now support its population of three billion must look forward to accommodating twice that many people by the year 2000.

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PERSONALS

Ben F. Banaham, Jr., has been elected rear-commodore of the Jackson Yacht Club for 1968. O. Weir Conner, III, also of Jackson, was named to the club's board of governors. The JYC has just sponsored its nationally famous Hospitality Regatta and additionally conducted a series of championship races before Christmas. The clubhouse and marina are on the Barnett Reservoir.

Warren N. Bell of Jackson was featured speaker at the annual meeting of the West Mississippi Medical Society conducted recently at Vicksburg. His topic was "Total Blood Cell Dynamics." He is director of clinical laboratories at the University Medical Center.

Paul R. Googe was honored by fellow Charlestonians recently on "Dr. Paul Googe Day." He has practiced in Tallahatchie County for 30 years and headed the hospital at Charleston until the new Tallahatchie General Hospital was opened in 1957. Topping the list of speakers for the occasion was Rep. Jamie L. Whitten of the Mississippi congressional delegation.

Jack B. Campbell, Martin B. Harthcock, Jr., James O. Manning, Heber Simmons, Kermit Till, and Henry Webb of Jackson have been elected directors of the Hinds County Unit of the American Cancer Society, Mississippi Division.

C. A. Jackson of Kosciusko has been serving on the task force of seven committees engaged in the study of long-range needs in vocational rehabilitation in Mississippi. He is a member of the committee concerned with deafness.

Charles M. Murry of Oxford is heading the Millsaps College fund drive in his area of the state. The overall objective of the college is to secure $3.75 million which will be matched by $1.5 million as a challenge grant from the Ford Foundation.

William E. Noblin, Jr., of Jackson recently addressed a meeting of the Woman's Cabinet on Public Affairs on the subject of family planning. He is director of the Division of Maternal and Child Care of the State Board of Health.

Willard H. Parsons of Vicksburg has been named emeritus professor of clinical surgery at the University Medical Center. Since the founding of the four-year school at Jackson, he has served as clinical associate professor of surgery.

W. Steve Sekul of Biloxi has been inaugurated president of the Coast Counties Medical Society for 1967-68. Serving with him as officers are Karl B. Horn of Pascagoula, president-elect; Robert H. Middleton, Jr., of Biloxi, vice president; C. Hal Cleveland of Gulfport, secretary-treasurer; and B. B. O'Mara of Biloxi, member of the board of censors. Dr. Cleveland served as president during 1966-67.

Thomas E. Stevens of Jackson was recently elected to membership in the American Society of Internal Medicine. Purpose of the society is to study the scientific, economic, social, and political aspects of medicine at state and national levels in the interest of better patient care and the highest standards of internal medicine.

W. W. Walley of Waynesboro was honored by Jones County Junior College as 1967 Alumnus of the Year. He served during the year as president of the alumni association. Dr. Walley also attended the University of Mississippi, and he received his M.D. degree from the University of Pennsylvania School of Medicine and his post-graduate training at the University of Alabama Medical Center.

Noel C. Womack, Jr., of Jackson has been named to the board of directors of the capital city's Better Business Bureau. He is engaged in private practice and limits himself professionally to pediatrics.

Dr. Barnett Wins Scientific Exhibit Award

Dr. William O. Barnett of Jackson, professor of surgery at the University Medical Center, was awarded second place honors in a field of 54 scientific exhibits at the 61st Annual Meeting of the Southern Medical Association at Miami. The subject of his exhibit was "Improving the Results in Strangulation Obstruction."

Co-authors of the exhibit were Drs. Robert I. Oliver and Walter R. Jones, Jr., residents in surgery at UMC. Three other scientific exhibits from UMC were also presented at the meeting.

Dr. Barnett's exhibit complemented his essay before the section on surgery. His topic was "Current Practice in the Management of Strangulation Obstruction."

Ole Miss Medical Alumni Will Build Permanent Facility on UMC Campus

Construction will begin this month on the Ole Miss Medical Center Alumni Building, a $650.000 structure which was three years in the planning. Medical Alumni Secretary Charles William Price of Jackson said that the new structure will provide a home for the association on the UMC campus while fitting into the long range development plan for the center.

The modern masonry, steel, and glass building will contain 26.000 square feet of usable space. At ground level, there will be a lobby, informal lounge, registration facilities, kitchen, snack bar, alumni offices, the resident manager's suite, and a large meeting room seating 250, capable of being divided into three smaller areas for simultaneous use.

The second floor will house 29 overnight accommodation units, including a suite with kitchenette and living room. The entire area will be carpeted, and storage and support units will be located on each floor. Adjacent parking will provide for 80 automobiles.

Price said that the building design is such as to support eight stories, and future expansion will be vertical, in keeping the UMC's long range development program. The building will be sited on the UMC campus utilizing three acres between the existing north roadway and the curved drive to the student apartments near Lakeland Drive.

Financing was arranged through the State Building Commission with a special issue of 25 year revenue bonds in the amount of $650.000. The indebtedness will be retired from building income which will be supplemented by alumni gifts.

The building program was initiated in 1965 when Dr. B. B. O'Mara of Biloxi was serving as president of the Ole Miss Medical Alumni. Since then, three succeeding presidents. Drs. W. E.



The new Ole Miss Medical Center Alumni Building will boast 26,000 square feet of space, meeting auditorium, food facilities, offices, and 29 overnight accommodations. Site of the building is the Jackson campus of the University Medical Center. Construction is scheduled to begin this month.



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Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Caldwell of Baldwyn, T. E. Wilson, Jr., of Jackson, and E. E. Ellis of Laurel, incumbent president, have furthered the project.

In October of 1966, the Board of Trustees of Institutions of Higher Learning approved the construction proposal, acting on the recommendation of the medical and general alumni associations and the University administration. The bond issue was approved by the Building Commission in December of 1966. Architects are Bouchillon and Harris, A.I.A., of Jackson.

Members of the present Alumni House Building and Steering Committee are Drs. E. E. Ellis, chairman; Wendall B. Holmes of McComb, vice chairman; J. Daniel Mitchell, T. E. Wilson, Jr., James Grant Thompson, Arthur C. Guyton, Thomas J. Brooks, William O. Barnett, and Mr. Price, all of Jackson.

Dr. Crawford Is Named to Board of Trustees

Dr. Everett Crawford of Tylertown has been named to serve the unexpired term of Dr. G. Swink Hicks of Natchez as a member of the Board of Trustees. Dr. Hicks announced his resignation recently as he assumed new duties as delegate to the American Medical Association from Mississippi.

Dr. Crawford previously served as a Trustee from 1957 until the 97th Annual Session in 1965 when he was inaugurated president of the association. He was named to the current term by Dr.



Congratulating the new District 8 Trustee, Dr. Everett Crawford, second from left, are Drs. G. Swink Hicks, former Trustee, Temple Ainsworth, association president, and John B. Howell, Jr., Board chairman.

Temple Ainsworth of Jackson, president of MSMA.

Dr. Hicks, also a past president of the association who served in 1960-61, is now a member of the Mississippi State Board of Health and a director of the Mississippi Hospital and Medical Service (Blue Cross-Blue Shield). He assumed his new post as AMA delegate Jan. 1, having been elected at the 99th Annual Session last year.

In announcing the appointment of Dr. Crawford, President Ainsworth praised Dr. Hicks' service to the association and the state and expressed confidence in his continuing his role of leadership. Dr. Ainsworth said that Dr. Crawford's leadership and service in Mississippi medicine have been outstanding and that the association is fortunate to have his service as a member of the Board of Trustees.

At its regular meeting on Dec. 7, the Board associated itself in Dr. Ainsworth's commendation to the two leaders.

The term for the District 8 Trustee continues through the 101st Annual Session in 1969. The district includes the Claiborne County, Homochitto Valley, South Central Mississippi, and Amite-Wilkinson Counties medical societies.

EMCU Opens to Serve Legislature

The state medical association's Emergency Medical Care Unit for the legislature will be opened in the New Capitol Building with the convening of the 1968 Regular Session. This was the announcement of the Council on Legislation under whose supervision the public service project is operated.

The care unit is located in Room 401-B of the Capitol where a registered professional nurse, an employee of the association, is on duty each legislative day. A Doctor-of-the-Day is scheduled from among volunteer members of the association. The care unit has minimal treatment room equipment.

The association has maintained the service for the legislature since the 1964 Regular Session, and it is being continued this year following an action of the House of Delegates at the 99th Annual Session in 1967.

Supervision of the unit is conducted by the Council on Legislation. Dr. George E. Twente of Jackson is council chairman and leader of association activities in the legislative field.

Members willing to serve as Doctor-of-the-Day are requested to communicate with the association's office at Jackson, specifying preferences as to a day of the week. The legislature is expected to meet Mondays through Thursdays during early months of the session.

Dr. Moreton Is SMA Award Recipient

Brookhaven-born Dr. Robert D. Moreton of Houston, Texas, was the 1967 recipient of the Southern Medical Association's Distinguished Service Award during the recent Miami annual meeting. He is now assistant director and professor of radiology at the M. D. Anderson Hospital and Tumor Institute at Houston.

A graduate of Millsaps College, Dr. Moreton received his medical certificate from the former University of Mississippi School of Medicine at the Oxford campus. His M.D. degree was earned at the University of Tennessee College of Medicine.

Prior to joining the M. D. Anderson staff in 1965, Dr. Moreton was in practice at Fort Worth. He is now also vice president of the University Cancer Foundation at Houston. In 1964-65, he served as president of the Southern Medical Association and is currently a trustee and chairman of the Committee on Insurance.

His postgraduate training included an internship at the Lloyd Noland Hospital at Fairfield, Ala., and a residency in radiology at the Mayo Clinic, University of Minnesota. He is formerly secretary of the Texas Medical Association and president of the Radiological Society of North America.

Crescent City Slates Graduate Medical Parley

The New Orleans Graduate Medical Assembly has scheduled its 31st annual meeting in the Crescent City for March 4-7, and the Roosevelt Hotel has been selected as headquarters.

Assembly officials said that 19 essayists have been scheduled for participation in a balanced, well-rounded program of wide interest. Fifty-one essays appear on the preliminary program in addition to a clinicopathological conference, a number of symposia, medical motion pictures, roundtable luncheons, and technical exhibits.

Entertainment and programs for physicians' wives are also planned. Of special interest to registrant-physicians will be a one-day premeeting symposium on "Sexual Problems in Clinical Practice," slated for March 3. Six papers will be presented together with a panel discussion.

Registrants are encouraged to write the Hotel Roosevelt for reservations. The all-inclusive registration fee is $30 per physician.

Three Cities Are UR Meet Sites

Dr. Virgil N. Slee of Ann Arbor, Mich., nationally recognized authority on utilization review, was principal speaker at a series of fast-paced conferences conducted at Jackson, Hattiesburg, and Gulfport. The series was jointly sponsored by the Council on Medical Service of the state medical association and the Mississippi State Board of Health with the cooperation of the Mississippi Hospital Association and the Mississippi Association of Medical Records Librarians.

At each conference, panels of local physicians, hospital administrators, and medical records librarians participated. In identically structured programs, Dr. Slee made the major presentation, followed by panel and audience discussion.

At Jackson, the conference was conducted at the St. Dominic-Jackson Memorial Hospital where more than 100 attended, among whom were 40 physicians. Dr. Ben F. Banahan, Jr., of Jackson moderated the program.

Panelists included Jackson Drs. I. H. Cronin and Calvin T. Hull, Dr. Donald T. Imrie of Vicksburg, and Richard H. Malone, administrator of Hinds General Hospital, and his medical records librarian, Beverly S. Powers, R.R.L., both of Jackson.

The Hattiesburg conference, conducted at Forrest General Hospital, was chaired by Dr. Frederick E. Tatum of Hattiesburg who was joined in panel discussions by Drs. Richard H. Clark, Van C. Temple, and Edgar D. Johnson. Other panelists included Forrest General Administrator Lowery A. Woodall and Sarah Q. Brown, R.R.L., the hospital's medical records chief.

Dr. Banahan made the junket to Hattiesburg to participate in the panel after moderating the Jackson conference.

At Gulfport, the meeting was moderated by Dr. C. D. Taylor, Jr., of Pass Christian, chief of staff of the Memorial Hospital at Gulfport, site of the conference.

Coast panelists included Drs. E. T. Riemann, Jr., and George W. Vickery of Gulfport and Memorial Hospital Administrator C. P. Wimberly.

Dr. Alton B. Cobb of Jackson, head of the State Board of Health division concerned with utilization review, accompanied Dr. Slee at each conference.

In each instance, panelists are members of utilization review committees, actively engaged in ongoing programs in their respective hospitals.

Dr. Slee is director of the Commission on Pro-





Utilization review conferences conducted in three Mississippi cities show, clockwise from top, panelists Drs. I. H. Cronin and Ben F. Banahan, Jr., as they listen to Dr. Slee; other Jackson panelists are Richard H. Malone, Beverly S. Powers, R.R.L., and Drs. Donald T. Imrie and Calvin T. Hull. Lower center are Gulfport panelists Drs. E. T. Riemann, Jr., George W. Vickery, and hospital administrator C. P. Wimberly. Bottom, Dr. Richard H. Clark addresses conference as Dr. Van C. Temple, left, and the moderator, Dr. Frederick E. Tatum, right, listen.





fessional and Hospital Activities, a nonprofit study and research organization jointly sponsored by the American College of Surgeons, American College of Physicians, American Hospital Association, and the Southwestern Michigan Hospital Association.

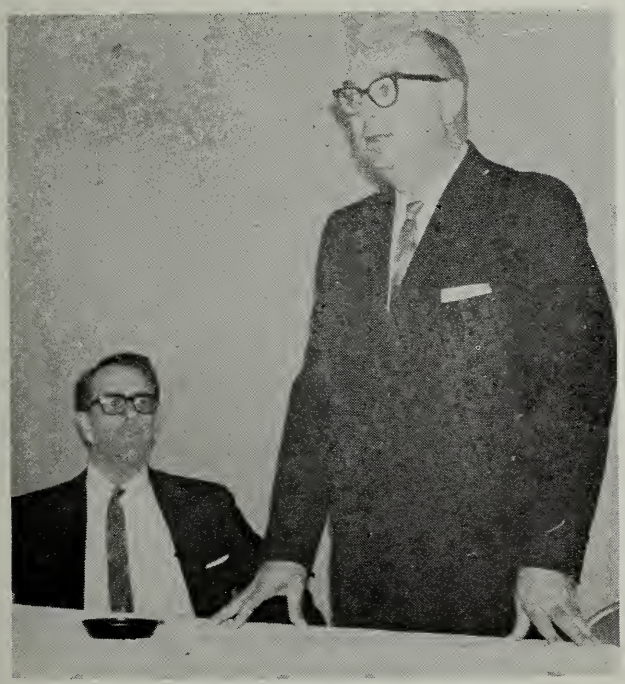
He regularly services thousands of hospitals in the United States and Canada, processing data on more than 8 million discharges annually. His organization has a staff of more than 200 individuals and makes use of two advanced versions of the IBM 1401 computer.

Dr. Slee told the conferences that his organization's data pool on utilization of hospital facilities now included almost 40 million patients.

While utilization review was brought into focus by Title XVIII of Public Law 89-97, Medicare, it is a concept endorsed by AMA in 1960 and is physician-developed. Dr. Slee described the two techniques of utilization review, the retrospective or after-discharge review, and the on-site review most usually associated with Medicare.

Utilization review, Dr. Slee said, is not punitive but rather educational and a self-administered project among physicians as members of a hospital professional staff. He said that a properly conducted program tends to strengthen physician authority and extends staff responsibility.

In addition to being a requirement for Medicare, utilization review is a precondition for accreditation by the Joint Commission on Accreditation of Hospitals.



Dr. C. D. Taylor, Jr., Memorial Hospital chief of staff, right, introduces Dr. Slee to Coast utilization review conference.

Overhead Expense Coverage Is Extended

Acting at its regular winter meeting, the Board of Trustees of the state medical association authorized an increase in limits of protection for the overhead expense plan offered on a group basis by the Continental Casualty Co. Members may now purchase coverage with which to pay office expenses up to $1,500 per month during periods of disability.

Dr. John B. Howell, Jr., of Canton, chairman of the Board of Trustees, said that the action increased available limits of coverage to $1,500 per month from the former level of $1,000 per month. A number of association members had requested that the plan offer the greater protection.

Overhead expense coverage is unique in that premiums paid are fully deductible from federal income tax as an allowable business expense. The coverage is easily tailored to the individual physician's requirements, since it may be purchased in units of $50. Assured members have the option of benefits beginning on either the 16th or 31st days of disability.

The plan, along with a number of other group offerings, is administered for the association by Thomas Yates and Co. of Jackson. The underwriter is the Continental Casualty Co. of Chicago. The new action leaves unchanged the premium rates and options available to members.

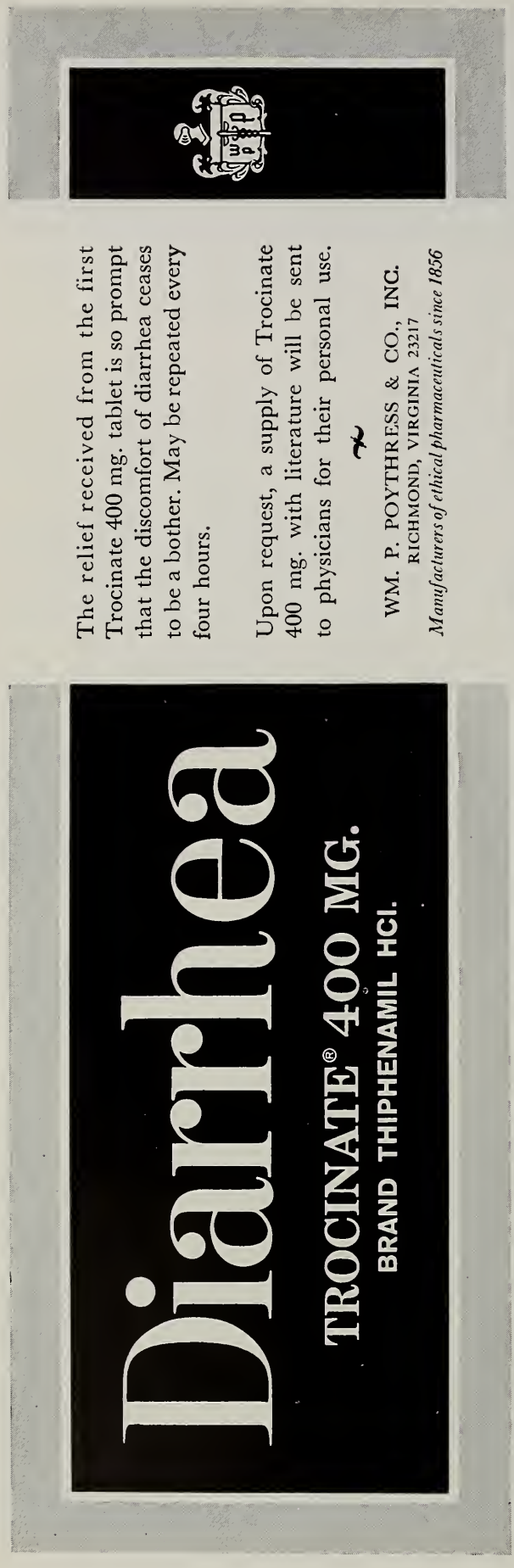
Scientific Exhibits Are Invited for 100th

Applications for scientific exhibit space at the 100th Annual Session have been invited by the Council on Scientific Assembly, according to Dr. Walter H. Simmons of Jackson, chairman. He said that it will be the council's objective to maintain the high quality and value of the educational offerings which have proved popular during past years.

"We have been extremely fortunate," Dr. Simmons said, "in the variety and teaching value of our scientific exhibits, particularly at the past two annual sessions.

"The council is hoping for a continuation of balanced, high-interest scientific exhibits, and premium space has been set aside for them at our big 100th," he added.

The chairman said that the Aesculapius Award will again be offered for the scientific exhibit by



a member of the association which is adjudged best. The award carries an honorarium of $200 in addition to a special plaque, he said.

For the best out-of-state scientific exhibit, the association's Scientific Achievement Award is presented. This is a special bronze medallion given in recognition of exhibit excellence, and it is engraved with the winner's name.

Dr. Simmons said that the application procedure is informal, requiring only a letter from the prospective exhibitor giving the title of his exhibit, a brief description of the presentation and format, the minimum number of linear feet of wall space needed, and any special requirements as to electrical service, illumination, and the like.

The invitation emphasized that final selection of scientific exhibits will be made by Feb. 15 and that letters of application, addressed to the Council on Scientific Assembly in care of the association at 735 Riverside Drive, Jackson 39216. should be sent as soon as possible.

RMP Sets Up Stroke Unit at UMC

A four bed demonstration unit for care of stroke cases has been established at the University Hospital in Jackson under the Mississippi Regional Medical Program. Funds from the MRMP planning grant have paid for equipping the unit and will also cover nursing staff and physician supervision but not patient care.

UMC spokesmen said that the four beds make little impact as to facilities and services available in the care of an estimated 13,000 new stroke patients each year in the state. The purpose, however, is to demonstrate optimum care for such patients, and it does make possible the delivery of this care. Previously, only moribund or hemorrhagic stroke patients could be admitted to UMC's limited neurology service.

To be considered for admission, the patient must be a nonveteran, have suffered an acute nonhemorrhagic stroke within 24 hours of admission, and show good potential for recovery and rehabilitation. Any practicing physician in the state may request admission of a patient by calling the admitting neurology resident. Arrangements prior to admission are mandatory, the statement said.

Length of stay in the unit is limited to two months as may be necessary for recovery from the acute phase and for rehabilitation to capability for self-care in daily living. Reimbursement for patient care is not covered under the Regional Medical Program grant.

The announcement said that the stroke unit team expects to share its experience in the total care of these patients with physicians, nurses, and therapists throughout the state who will be invited to participate in traineeships established in the unit. The training will include the total care concept as well as psychosocial and vocational support techniques.

MPHA Speakers Discuss State Health Programs

Two public health leaders challenged the state to organize its health service planning by designating an agency to carry out programs of the Comprehensive Health Planning Act of 1966, now succeeded by the Partnership for Health Amendments of 1967.

Drs. A. L. Gray of Jackson and J. Robert Lindsay of Atlanta, regional director of the U. S. Public Health Service, pointed out that Mississippi is the only state in the nation which has not initiated action under the program. The statement came at the recently conducted annual meeting of the Mississippi Public Health Association at Jackson.

Dr. Lindsay said that the health components of the state are fitted together "crudely in a sprawling and largely uncoordinated way."

Dr. Gray, executive officer of the State Board of Health, said that "Mississippi is the only state which has not designated an agency to implement this overall planning as required under congressional act. A large majority of states has designated the state health agency to implement this program.

"This designation can be done by the governor or the legislature of respective states," Dr. Gray said. "I think it is logical to insist that the State Board of Health is the most experienced agency in the state to do this," he added.

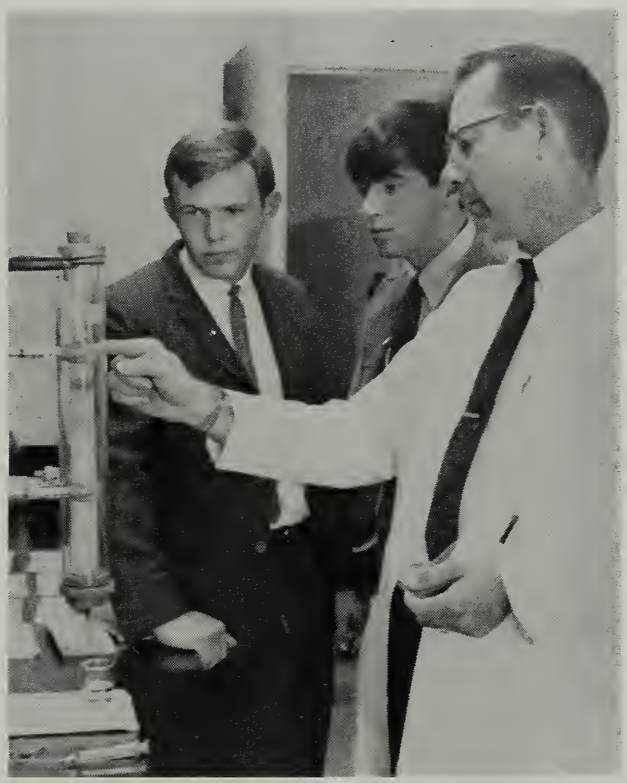
In 1966, the Mississippi State Medical Association requested Governor Paul B. Johnson to assign this task to the State Board of Health. Neither the governor nor the legislature has acted to designate an agency for the coordinated planning. The state medical association has also called attention to the fragmented health care programs in Mississippi.

In other remarks before the public health association, Dr. Gray said that the system of multiple federal health care programs is seriously weakened by political intrigue. He called the Bolivar County OEO-funded health care project under Tufts University "a real monstrosity."

Dr. Gray said that "the apparent intent of the Research and Development Center (of Mississippi) is to envelop all facets of necessary progress, including health and medical care to at least some extent."

1966-67 president of the public health group was Zona C. Jelks, R.N., of Jackson who is state director of public health nursing. The new president is Roland B. Shows of Ellisville, regional disease investigator for the State Board of Health. The annual meeting was conducted at Jackson.

UMC Sponsors Visit Day for Premed Students



Premedical students from Mississippi's junior and senior colleges converged on the University Medical Center campus for the annual pre-med day, paired this year with Heart Research Day which was co-sponsored by the Mississippi Heart Association. Dr. M. Don Turner (far right), associate professor in the departments of surgery (research) and physiology and biophysics at the Medical Center, shows visiting students a demonstration keyed to research aspects of departmental work.



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Heart Association Will Make Research Awards

The Mississippi Heart Association has announced that applications for research grants-in-aid for 1968-69 are being received in preparation for making awards on July 1. The deadline for grant application, the association said, is March 1.

The heart association grants are made to nonprofit institutions in direct support of an investigator who has received his doctorate within the year prior to the award. The research must be in the cardiovascular field or basic sciences related to it, and the projects can receive support for as long as three years. In addition to the grants, the heart association also supports the Mississippi Love Research Professorship of Cardiology at a level of $20,000 annually.

The announcement of the grants-in-aid also said that "except under unusual circumstances, the amount of the grant will not exceed $2,000." After the March 1 deadline, the applications will be reviewed by the Research Grants and Fellowships Committee. Approval actions are anticipated by April 1, and actual awards will be made July 1.

For 1967-68, the heart association granted $45,500 for departmental fellowships in the University of Mississippi. Those at the UMC campus included fellowships for the departments of Physiology and Biophysics, Medicine, Pharmacology, Surgery, Biochemistry, and Anatomy. Another fellowship award was made to the Department of Pharmaceutical Chemistry at the Oxford campus.

The association also awarded $14,000 in grants-in-aid to the following UMC investigators:

—Dr. Luis G. Navar, "Intrinsic Regulation of Renal Hemodynamics."

—Dr. Howard T. Milhorn, Jr., "On-line Studies of Respiratory Control."

—Dr. Arthur S. Hume, "The Effects of Some Substituted Phenethylamines on the Cardiovascular System."

—Dr. Oliver E. Bell, Jr., "Mechanism of Fatty Acid Transport from the Adipose Tissue Cells and Subsequent Relationship to Aging and Atherosclerosis."

—Dr. Robert E. McCaa, "Hypertension and the Control of Renal Sodium Excretion."

—Dr. J. S. Wilkinson, "Studies on Fibrinogen and Fibrin."

Each of the investigators holds the Ph.D. degree. Another Ph.D., Dr. George F. Crozier of the University of Southern Mississippi at Hattiesburg received a grant-in-aid for "Comparative Study of Simple Cardiovascular Systems Under Conditions of Environmental Stress."

CHAMPUS Will Offer Usual, Customary Fees

The Civilian Health and Medical Program of the Uniformed Services, formerly the Dependents' Medical Care Program, original military Medicare, has announced procedural changes and a move toward payment of physicians fees on a usual, customary, and prevailing basis. This was the announcement of Brig. Gen. Norman E. Peatfield of Denver, Colo., executive director of the program.

The announcement assures initiation of usual, customary, and prevailing fees by March 1. Drs. Temple Ainsworth of Jackson, president; John B. Howell, Jr., of Canton, chairman of the Board of Trustees; and Walter H. Simmons of Jackson, secretary-treasurer and chairman of the State Medicare Review Board, said that the alteration in fee concept had been considered by the Board of Trustees at its December meeting. The association, they said, expects to make further announcements in this connection in the immediate future.

At present, only Part 1-B of Title XVIII Medicare is paying usual and customary fees in Mississippi, except for Workmen's Compensation which carries no fee schedule as such.

Drs. Ainsworth, Howell, and Simmons also said that the widely publicized edict of the Department of Defense to remove fiscal administration of the CHAMPUS program from state medical associations has been rescinded. This announcement was made known by DOD officials just recently.

Procedural changes include use of new claims forms for physicians, hospitals, and others involved in the comprehensive care program. A new DA Form 1863-1 for hospitals, colored blue, is being distributed, as are new DA Forms 1863-2 for physicians and other sources of care. A third form, 1863-3, is for care of the handicapped, one of the newer aspects of the program.

Claims in process on old forms will be serviced, but physicians are being requested to use the newer forms as soon as possible. Usual, customary, and prevailing charges should be billed, as has been the practice since 1960 under the program. Until the changeover in fee concept is made, reimbursement will be made under the maximum fee concept.

The new and expanded program which now furnishes outpatient care and includes retired personnel has resulted in an unprecedented upsurge of claims. Association spokesmen said that claims volume has increased 400 per cent, resulting in a backlog. The association's department servicing the claims has been doubled in staff and expects to reduce the backlog as such within 30 days, placing the program on its former current basis.

Nutritional Status Study Is Initiated

A statewide study of the nutritional status of Mississippi's preschool children has been initiated with a survey team of health specialists moving into Humphreys County.

Part of a nationwide research program entitled "Evaluation of Nutritional Status of Preschool Children in the United States" financed by a Children's Bureau grant, the Mississippi pilot study is sponsored by the Mississippi State Board of Health, the University of Mississippi Medical Center, and the Children's Hospital Research Foundation of Columbus, Ohio.

Twenty representative counties, scattered throughout the state, have been selected for the project. They are Carroll, Coahoma, Copiah, Covington, Forrest, Franklin, Harrison, Itawamba, Kemper, Lowndes, Madison, Pike, Rankin, Scott, Stone, Tallahatchie, Tippah, Tunica, Yalobusha and Humphreys.

The children studied will be chosen from the total population by random sampling by computer without regard to race, creed, national origin, or socio-economic levels. Participation in the project will be voluntary.

Dr. A. L. Gray, state health officer, in lending his support to the program, said, "We want the truth about our young children. This comprehensive survey, which will make use of scientific techniques, will furnish us an accurate picture of the nutritional status of our little ones from one to six years of age and point the way to a better understanding of their health needs."

The state health officer urges parents to cooperate in the undertaking. In addition to furnishing data for use in state and national programming, Dr. Gray says there will be a direct benefit to each child selected for study.

One phase of the survey calls for a comprehensive physical examination of each child by a pediatrician, who will make use of extensive laboratory tests. Local health departments are pro-

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viding clinic space for the examinations, which will be made by specialists who are members of the survey team. Transportation to the clinic, as well as the examination, will be provided at no cost to the family.

Dr. Gray says that each family will be notified of the results of the examination. When abnormalities are uncovered, the report of the examination will be made available to the private physician or clinic designated by the child's parent. Follow-up care will be provided by the health department as indicated.

The physical examination follows a home interview conducted by a dietary interviewer in which a three-day food intake record is obtained.

Fifteen experienced home economists and dietitians have been employed as dietary interviewers and are now receiving orientation at the State Board of Health in Jackson. Nine of the interviewers are from Mississippi, two are from Louisiana, and four, from Ohio.

The director of the national survey, Dr. George M. Owen, associate professor, Department of Pediatrics, Ohio State University and Children's Hospital Research Foundation, has been in Mississippi in conference with authorities at the State Board of Health and the University Medical Center in preparation for the undertaking. He is being assisted by Miss Kathryn Hedges, research associate, Ohio State University, who will remain in the state until the survey is completed.

Serving as advisory coordinator in Mississippi is Miss Geraldine McCall, who for 20 years was merit system supervisor for the State Board of Health.

PMA Defends Drug Costs, Development

America's prescription drug industry is continuing its emphatic denial of charges leveled at it during recent months by witnesses before a congressional subcommittee.

The industry, represented by the Pharmaceutical Manufacturers Association, has had but one opportunity thus far to defend itself before Sen. Gaylord Nelson's (D.-Wis.) Monopoly Subcommittee of the Senate Select Committee on Small Business. Many witnesses appearing before the committee have criticized the industry, certain of its products, and allegedly "high drug prices" since the hearings opened last May.

In its first defense—on Nov. 16—PMA President C. Joseph Stetler used government statistics to demonstrate to the committee that "all available price indices" show that drug prices are actually declining while other prices are rising.

He also pointed out that the price differences paid for drug products marketed by brand names and those marketed under generic names "are not nearly so high as statements of previous witnesses would have one believe." In this connection, he termed the doctrine of "generic equivalency," which has been mentioned frequently during the seven months of the Nelson hearings, "a dangerous oversimplification of a complex medical problem."

Other witnesses, who had originally been scheduled by Senator Nelson to appear at the Nov. 16 hearings were:

Leslie M. Lueck, director of quality control, Parke, Davis and Co. of Detroit, who disclosed that scientific tests of four competing and supposedly identical antibiotic products show that only one of them meets all federal labeling requirements. He said his company has "confirmed what experts have repeatedly said, that chemical similarity is not necessarily indicative of therapeutic equivalency," even though all the products tested had passed existing government test requirements.

Dr. A. E. Slesser, associate director of quality control, of the Smith Kline and French Laboratories of Philadelphia, who stressed that the standards of the U. S. Pharmacopeia and the National Formulary do not pretend to include all the specifications and tests that a highly skilled, conscientious manufacturer requires his product to meet before he will put his name on it.

Dr. Leonard A. Scheele, president of the Warner-Lambert Research Institute, former U. S. Surgeon General, who said that the average industry expenditure to develop a successful new single drug entity is $7 million. There are many instances where molecular modification has led to major advances, he said.

Dr. Hart E. Van Riper, vice president of Geigy Pharmaceuticals in Ardsley, N. Y., and former medical director at the National Foundation for Infantile Paralysis, who indicated that the last major congressional investigation of the drug industry from 1959 to 1962 resulted in laws and regulations which have already "added materially to the cost and the time required to develop a new drug product."

Leland W. Blazey, vice president, manufacturing and engineering, McNeil Laboratories, Inc. of Ft. Washington, Pa., who testified that the quality-conscious prescription pharmaceutical

firms go far beyond basic FDA requirements. He cited a routine operation by his company in which 687 inspections and tests are made before the drug is finally turned into a finished product.

Before PMA testified, a total of 30 witnesses had appeared before the Nelson subcommittee during its seven months of hearings.

Pfizer Gives AMA-ERF $50,000

The sixth annual grant to the student loan guarantee program of the American Medical Association's Education and Research Foundation has been made by Chas. Pfizer & Co., Inc.

The $50,000 grant was accepted by Dr. Charles Hudson, president of the AMA Education and Research Foundation. It was presented by Dr. George W. Brice, associate medical director, Pfizer Laboratories Division. The new grant brings the total sum contributed by Pfizer to the program to $450,000.

The latest $50,000 grant will release $625,000 credit for loans to medical students, interns and residents. Each $100 in the fund backs up a $1,250 loan which is repaid after the student completes his training and is in practice.

The new Pfizer grant brings the total in the loan guarantee fund to $3,580,000, which gives it a total loan power of over $44 million. Of the total $41 million is already committed to back up loans. These loans, which total about 35,000, have been made to approximately 19,250 medical students, 10,500 residents and 5,250 interns. Recipients of the loans are in training in more than 660 medical schools and hospitals throughout the country. An average of 600 loans are made each month.

In making the presentation, Dr. Brice pointed out that "between the desire and the fulfillment of a medical education lies a financial barrier which in too many cases is all put impassable. We at Pfizer are only too happy to be able in some way to help worthy students overcome this barrier. By so doing, we are helping to insure that the benefits of the research efforts undertaken by Pfizer and other members of the pharmaceutical industry will be utilized by an ever-growing number of skilled physicians."

He said that the loan guarantee program is "an outstanding example of individual enterprise" designed to help students to help themselves along the path to becoming practicing physicians. He

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praised the progress of the program and added that Pfizer was pleased to make its sixth annual grant at this time.

In addition to its six grants to the loan guarantee program Pfizer also maintains a medical school scholarship program. For each of the past six years, the Pfizer Laboratories Division has made available to each medical school in the United States a $1,000 scholarship. These scholarships are administered by each of the nation's over 90 medical schools and awarded entirely at the discretion of the individual school.

Measles Is Jet-Gunned in Coast Program

Harrison County physicians, the Gulfport Junior Auxiliary, and the Harrison County Health Department combined forces to conduct a pre-Christmas immunization program against measles. Heading the medical team was Dr. C. D. Taylor, Jr., of Pass Christian, chief of staff of the Memorial Hospital at Gulfport and a member of the association's Board of Trustees.

Dr. A. N. Morphy of Gulfport, director of the county health department, and Mrs. W. D. Atchison of Gulfport, wife of Dr. W. D. Atchison, headed their respective organizations' effort in the campaign.

The program was a Sunday afternoon project limited to children. Nine immunization stations were strategically and conveniently located throughout the county with physicians manning each. Injections were given by jet gun.

The immunization campaign was deemed highly successful. Gulf Coast physicians have previously conducted oral poliomyelitis immunizations in a similar campaign.

UMC Names Three New Faculty Members

Three new and recent appointments have brought the number of full-time University of Mississippi School of Medicine faculty to an all-time high of 129.

Added at the rank of assistant professor in the Department of Physiology and Biophysics is Dr. Thomas Coleman. Dr. Coleman completed the requirements for the Ph.D. degree at the University Medical Center in October. He also holds the B.S. degree from the University of Rochester and the M.S. degree from Mississippi State University.

New instructors are Dr. Barry Aden, anesthesiology, and Dr. Robert E. McCaa, medicine (research). Dr. Aden received his M.D. degree from the University of Mississippi School of Medicine and took his internship and residency training at the University Medical Center. Dr. McCaa holds the B.S. degree from Mississippi College and earned the Ph.D. degree at the University of Mississippi Medical Center.

Coast Physician Is Cited for Service in Tornado

Dr. John F. Russell of Gulfport has received the Mayor's Good Citizenship Citation for outstanding service during the November tornado devastation of the Handsboro-Mississippi City area. Dr. Russell left his own damaged home and his family to render care to the injured.

The citation stated that Dr. Russell "voluntarily abandoned his own personal and private affairs to assist in the disaster relief work at the tornado site. Dr. Russell spent long hours working among the many scores of injured, giving medical aid and comfort on the scene. He is known to have personally treated more than 100 persons.

"For his alertness, his untiring zeal, and his unselfish contribution to the people of our city in their hour of need, we offer this citation to Dr. Russell, together with the heartfelt thanks of our entire city."

Hospital Addition Honors Dr. Gillespie's Memory

A new 17-room addition to the Greenwood-Leflore Hospital has been named in honor of a long-time member of the Delta Medical Society and state association. The G. Y. Gillespie Section will honor the memory of the late George Yancy Gillespie of Greenwood.

The new addition, formally opened when Mrs. Gillespie cut a ribbon, brings the modern Delta hospital to 185 beds in a program to provide all private room accommodations. The new section was formerly occupied by the school of nursing.

The administrator of the hospital, Thomas L.



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It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

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You might also say that all interns aren't alike, either.



Askew of Greenwood, presided, and Dr. Howard A. Nelson of Greenwood, a past president of the association, presented Mrs. Gillespie with a portrait of the late Dr. Gillespie to be displayed in the new addition.

The hospital was built in 1952 and is considered one of the most modern community hospitals in its area.

Computer Eases Burden of Medicare Paper

Mount Carmel Mercy Hospital in Detroit has applied some preventive medicine to a potential accounting headache posed by the surge of patients covered by the Medicare program. The remedy was developed on an RCA 301 computer at the hospital data processing center. It consists of a special computer program designed to handle the vast amount of paperwork associated with the Medicare plan.



In the computer room at Mount Carmel Mercy Hospital in Detroit, Sister Mary Hilda asks RCA 301 computer to start special program that handles billing for surge of patients covered by the Medicare program. The computer program has expedited billing and reimbursement that otherwise would have required many hours of extra clerical work.

Programmed to cope with countless calculations required by Medicare in figuring patients' prorated charges, the system is expediting in-patient billing and reimbursement that otherwise would require hours of extra clerical work.

Sister Mary Dolora, R.S.M., Administrator of the 559-bed hospital, said the RCA computer also has provided increased accuracy and control of each patient's billing record, and precisely tabulates the amount of each person's hospital insurance coverage under the Social Security Act.

Underscoring the importance of this system, Sister Mary Dolora pointed out that Mt. Carmel —one of 24 hospitals operated by the Sisters of Mercy in its three-state Midwestern Province— handles 20,000 in-patients a year, nearly 40 per cent of whom are covered by Medicare.

Sister Mary Dolora said that charges are recorded, key-punched and stored in the computer memory each night and the file containing approximately 6,000,000 charges, is updated daily. The Medicare application is operating within the system's accounts receivable program which handles regular admission, billing and emergency in-patient records.

Ayerst Aids in Parathion Poisonings

The recent parathion pesticide poisonings in Tijuana, Mexico, and Chiquinquira, Colombia, called on U. S. pharmaceutical manufacturers for emergency action to rush life-saving drugs to the scenes of the tragedies.

Because of the nature of the poison, there was dire need for a cholinesterase reactivator. Such a drug, Protopam Chloride® (pralidoxime chloride), is manufactured by Ayerst Laboratories of New York.

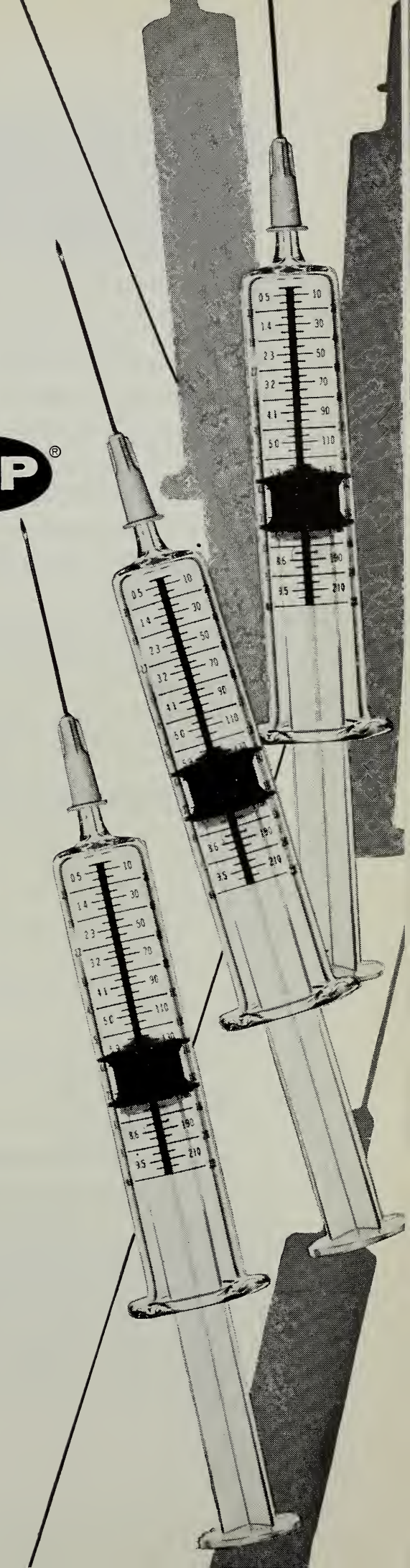
Since immediate treatment is imperative in this type of poisoning, fast action was needed to place supplies of Protopam Chloride in the hands of physicians in the disaster areas. In each instance, Ayerst Laboratories cooperated with local and state police agencies to help speed the antidote to nearby international airports. The company sent several hundred vials of the injectable form of the medication, which was used in conjunction with atropine sulfate.

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Pfizer Will Appeal Antitrust Verdict

Chas. Pfizer and Co., one of three defendant corporations found guilty of antitrust violation in the manufacture and distribution of $1.7 billion worth of antibiotics, has announced that it will appeal the decision of the trial court. The other defendant firms are American Cynamid and Bristol-Myers.

The Pfizer statement said that "we disagree with and are deeply disappointed by the verdict and we shall continue to fight vigorously for vindication. The verdict, in our view, could only have been based upon unjustified inference and suspicion. Each of the steps taken by Pfizer in marketing its broad spectrum antibiotic products was based upon normal and independent business practices. These facts could appear 'suspicious' only if the existence of a conspiracy were assumed. No direct proof of conspiracy has ever been offered—and indeed no conspiracy existed.

"We at the same time recognized that the jury was confronted with a formidable task. Day after day, it was faced with a profusion of complex facts dealing with chemistry, Patent Office practice, licensing, sales and marketing, economics and accounting. The jury was then asked to apply vague principles of antitrust law to this record of more than 5,000 transcript pages and more than 1,000 pages of documentary exhibits.

"We did not conspire with anyone and we did not monopolize. We made our own decisions, independently and for the best interests of our company—and we believe for the best interests of the public. It is unfortunate that the trial occurred in an atmosphere of unfavorable publicity about the drug industry, emanating over the years and during the trial from Congressional investigations and debates.

"We are not guilty of the charges made against us, and we look forward to pursuing this case further in the courts."

Wire service reports of the trial at New York City said that the precedent-making case marked a significant confrontation between the U. S. government and the pharmaceutical manufacturing industry. A U. S. District Court jury of 11 men and a woman found the three corporations guilty of restraint of trade, conspiracy to monopolize and actual monopoly.

Maximum penalties under the verdict are $150,000 in fines against each defendant corporation, but the court decision opens the way for civil suits from major purchasers of antibiotics.

The Sherman Antitrust Act provides for treble damages in civil actions against violators.

The trial began in Oct. of 1967 and continued for more than two months. Charges alleged that the firms entered into arrangements during 1953 to 1961 to manufacture and distribute antibiotics in violation of the Sherman Act.

The Justice Department named the Olin Mathieson Chemical Corp., whose drug division is E. R. Squibb, and the Upjohn Co. as co-conspirators but not as defendants. Allegations were that the defendant companies agreed to limit the manufacture of tetracycline to themselves.

Dental Leader Urges Insurance Coverage

A prominent dentist has urged the insurance business to be bold in its experimentation with dental coverage.

Dr. Kenneth J. Ryan, president of the National Association of Dental Service Plans, speaking before the Eastern Leadership Conference of the Health Insurance Council at New York, said that the insurance business should play an increasingly vital role in providing dental care expense protection for the American public.

He urged insurors to "speak with representatives of the dental profession," adding that official bodies of dentistry "are the most forward looking, liberal-minded of all medical type organizations."

Dr. Ryan said that there were certain "basic ingredients" necessary to the development of a "good dental package." He listed the following:

—Development of group programs.

—A more intimate knowledge by insurors of dentistry itself.

—Meeting with dentistry on all levels.

—Making informational materials available in connection with insurance plans.

—Improving communications on dental coverage between insurance companies.

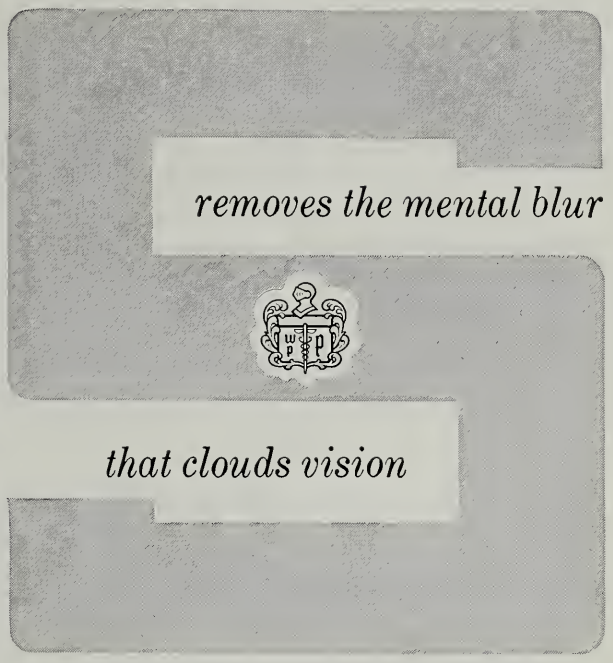
—Increased use of the "uniform claim form."

—To be patient with dental review committees once they are established.

—Standardize dental insurance nomenclature.

Dr. Ryan cautioned that dental service plans and the insurance business "should not try to monopolize pre-payment dental plans," and that "massive bureaucratic monstrosities should be avoided at all costs."

He said that good, liberal dental plans must be made attractive to both patient and dentist if they are to be effective.



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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

February 1968

Dear Doctor:

As the Legislature gets into high gear, the optometrists have moved quickly to introduce a measure to license and control ophthalmic technicians. Measure is HB 39, introduced by Rep. Alton Massey of Kosciusko. Net effect of enactment would be for optometrists to control licensure of M.D.'s employees in practice of ophthalmology.

> State medical association vigorously opposes bill, asserting that there can be no nonmedical controls over medical practice. The bold move suggests precedents of importance to all physicians who are urged to consider its implications and act accordingly with representatives and senators.

Striking the hardest blow yet at tobacco, the American Cancer Society advocates termination of all cigarette advertising. ACS Board of Directors says that it hopes for termination by voluntary self-regulation by tobacco industry and that "governmental action will not be necessary." Action also recognized that new advertising would have to be developed.

Only Mississippi and American Samoa have no designated state agencies for Comprehensive Health Planning and Partnership for Health programs. The enactments assist states in assessing their own health service programs and needs. Most governors and legislatures have designated state health agencies as coordinating mechanisms, and MSMA has recommended State Board of Health for the task here.

The only new angles in federal income tax - due soon, too - relate to deductions for medical expenses. Preferential treatment for those over 65 is discontinued for 1967 reporting, and the 3 per cent limitation for those under 65 now applies to seniors. One-half of premiums for medical insurance up to $150 is deductible and is not subject to 3 per cent limitation. Premiums above $150 are subject to 3 per cent rule.

LBJ's foreign travel tax won't be a problem for those taking American College of Surgeons trip to Germany in June. ACS has chartered six jets for the June 26-29 meeting at Munich with two leaving from Chicago, two from New York, one from Los Angeles, and one from Atlanta. Round trip fare ranges from $216 to $349 and side tours are allowed.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Group Practice Gains In Medical Faculties

Evanston, Ill. - The Association of American Medical Colleges says that 22 four year medical schools have formal group practice arrangements for clinical faculties, and 16 schools are planning such organizations for private practice. Fourteen of the groups are organized as parts of the schools but bill patients separately. Most plans use practice income as salary supplements, and half allocate up to 25 per cent of income to overall school programs. All but six faculty groups have income ceilings.

AMA Nixes Rx Drugs For Medicare

Chicago - AMA's Board of Trustees has endorsed a policy proposal by the Council on Medical Service which opposes "expansion of Title XVIII (over-65 Medicare) to include payment for outpatient prescription drugs on the basis of the long-established position that tax funds can be more effectively used when assistance in financing health costs is limited to those in need." AMA is for Rx drugs under Title XIX because of direct applicability to need. Policy also supports physician freedom to prescribe either generically or by brand.

New York Tribunal Invalidates Osteopaths' "M.D." Degrees

Albany - The New York State Supreme Court overruled the state osteopathic society and declared that the unearned M.D. degrees conferred on osteopaths under California law are canceled, revoked, and rescinded. After "marriage" of medicine and osteopathy in California, D.O. graduates were accorded "M.D." Problem has been movement of such practitioners from California and their attempts to secure M.D. license in other states.

Half Million Pilot Exams Are Seen In 1968

Washington - The Federal Aviation Agency's Office of the Civil Air Surgeon reports that an estimated 464,000 medical examinations will be done by aviation medical examiners in 1968 for airman certificates. An index to the growth of aviation generally and private flying particularly, this represents an increase of 57 per cent in number of examinations in just five years. FAA seeks additional AME's among private physicians.

New AMA Impairment Guide Is Available

Chicago - AMA's Committee on Rating of Mental and Physical Impairment has announced publication of its 11th evaluation guide, this one for rating impairment of the reproductive and urinary systems. Single copies are free to AMA members on written request to Chicago headquarters. Previous guides cover impairment evaluation of extremities and back, eyes, heart, ear-nose-throat, central nervous system, digestive tract, peripheral spinal nerves, respiratory system, endocrine system, and mental illness.

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Insurance Industry Will Aid Health Planning

Health insurers will more and more join with government at all levels, and with philanthropic forces, in planning for health facilities, services and needed personnel, a health planning expert told an insurance audience in New York.

In an address before the Eastern Leadership Conference of the Health Insurance Council in New York, C. Rufus Rorem, Ph.D., C.P.A., a special consultant to the Health and Hospital Planning Council of Southern New York, Inc., described insurance and taxation as "community efforts to rationalize current health financing."

As the main providers of current revenue, he said, it is only natural that taxing and insuring agencies would be interested in the costs of construction and current operation of health services and facilities.

The leadership conference brought together insurance executives from the eastern half of the nation who serve as coordinators in the new Health Insurance Council project for Community Health Action-Planning (HiCHAP). Also in attendance were chairmen of HIC state councils, other insurance men active in comprehensive health planning, regional officers of the U. S. Public Health Service, and representatives from allied and health organizations.

Dr. Rorem, in his paper titled "Relationship of Planning to the Quality and Cost of Medical Care," underscored the need for cooperative action among all health service institutions, rather than independent decision making.

"A health facility," he said, "should be established, modernized or expanded solely in response to proven community need, not merely the desires of the institution."

Noting that much health facility construction has been undertaken without regard to total community need, Dr. Rorem added that while many metropolitan areas contain an abundance of such facilities and services, serious scarcities exist in other areas.

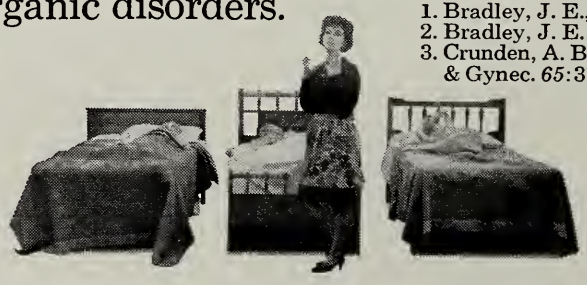
Dr. Rorem defined the essential function of a health planning group as one of assisting each institution to "examine its own program, to understand total health needs, and to make its optimum contribution toward meeting them."



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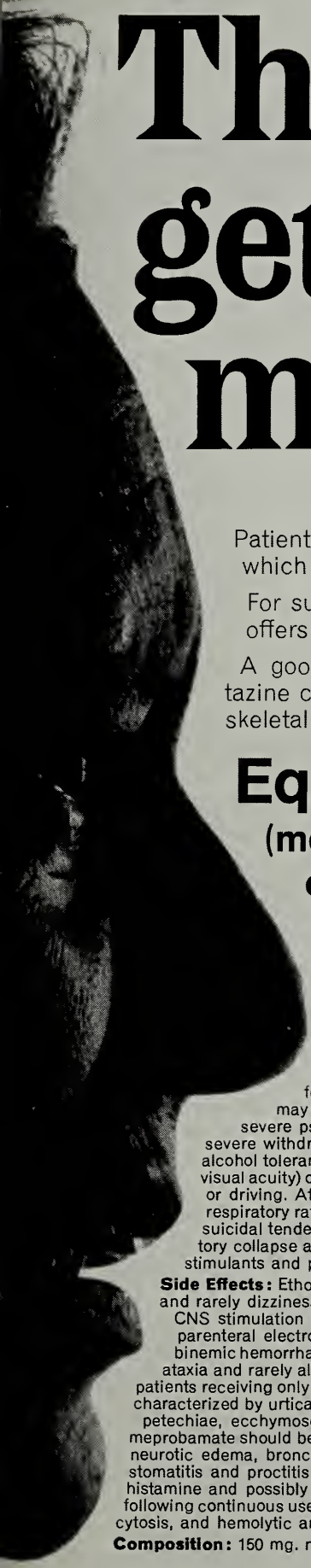
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Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

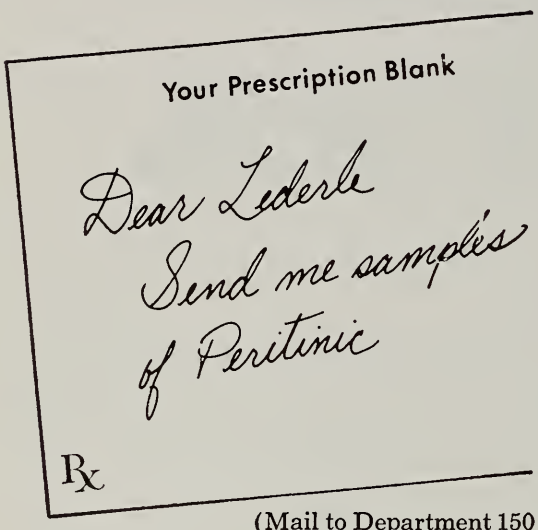
Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

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U. S. MD's Staff Viet Nam Eye Program

Fourteen months ago volunteer American physicians launched a new battle in South Viet Nam against eye disease. At the request of the Viet Nam government, an ophthalmology program was started at Vinh Long Provincial Hospital in the Delta south of Saigon.

The first volunteer was Dr. W. Conrad Stone of Roanoke, Va., who started organizing the program in October 1966. The need for major eye treatment had been underscored by a U. S. military medical team that discovered extensive eye disease in the Delta.

Dr. Stone spent two months in Viet Nam under the auspices of the American Medical Association Volunteer Physicians for Viet Nam program.

When Dr. Stone returns in January to begin a second two-month tour, he will find progress is being made toward the long-range goal: establishment of a full-fledged eye center for South Viet Nam.

But more volunteers are essential to keep the program advancing. Dr. Charles H. Moseley, director of the AMA volunteer program, said 12 ophthalmologists are needed in 1968 in order to maintain two in Viet Nam at all times.

People are seeing now who never saw before as a result of the eye program, Dr. Moseley said. Many cataracts have been removed and children who needed glasses are getting them he added, and the Vietnamese people have enthusiastically embraced the program.

The eye program, Dr. Moseley explained, is designed to provide care, preventive medicine, an improvement in the administration of the Vinh Long Ophthalmology Service, and teaching of Vietnamese medical students.

The Viet Nam Ministry of Health has agreed to assign senior medical students to residency training at the eye clinic, which is the only one of its kind in the country.

When Dr. Stone returns he will be accompanied by Robert C. Maher, M.D., Spokane, Wash. They will relieve Dr. Roger A. Thill of Harbor City, Calif.

Other physicians who have volunteered to develop the eye program are Drs. Bernard M. Teschner, White Plains, N. Y.; Robert D. Reinecke, Boston, Mass.; Loran B. Morgan, Torrington, Wyo.; Jose I. Zubero, Jacksonville, Fla.; Mark B. Jenson, Provo, Utah; C. Reid Roberts, Boston, and Richard S. Fixott, Colorado Springs, Colo.

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ORIGINAL PAPERS

Pancreatic Cystadenoma: Report of a Case

JESSE T. DAVIS, JR., M.D.; CARLOS M. CHAVEZ, M.D.; ELIZABETH FERRINGTON, M.D.; WILLIAM R. FAIN, M.D., and J. HAROLD CONN, M.D.
Jackson, Mississippi

Approximately 10 to 15 per cent of pancreatic cysts have been found to be neoplastic. Twenty-two cases of pancreatic cysts were recorded at the University Hospital and the Veterans Administration Hospital from 1955 to 1967. Only one patient had a neoplastic cyst, a cystadenoma, which was discovered during laparotomy for chronic cholelithiasis. The case is reported.

Of the abnormalities of the pancreas, chronic pancreatitis and neoplasms are considered the most common; cysts occur less frequently. These include congenital, traumatic, retention, and neoplastic cysts (dermoid with cystadenocarcinoma and cystadenomas) each one of which has individual clinical and pathological characteristics.[1]

Approximately 10 to 15 per cent of pancreatic cysts have been found to be neoplastic.[2, 3] During the 12-year period from 1955 to 1967, 22 cases of pancreatic cyst were recorded at the University Hospital and Veterans Administration Hospital of Jackson, Miss. Of this series, only one patient had a neoplastic cyst, a cystadenoma. The rareness of this lesion prompted this case report.

CASE REPORT

H. B., a 75-year-old white male, was admitted to the Veterans Administration Hospital of Jackson, Miss., in March 1967 with a three month history of cramping epigastric pain, nausea, and vomiting. Relief from pain was obtained after vomiting or antacid therapy. Residual pain persisted for approximately 24 hours after these attacks, which became more frequent during the month prior to admission. Except for a 10 pound weight loss during the preceding year and dark urine following each attack, the patient had no other pertinent symptoms at the time of admission. There was no history of hematemesis, melena, alcohol intake, hepatotoxic medications, chills, fever, or blood transfusions. The patient recalled two episodes of jaundice in the past.

Upon physical examination the patient's blood pressure was 130/70, the pulse 80 and regular, and temperature 98.6 F. The patient presented as a mentally clear, well-developed, thin white male,

From the Departments of Surgery, University of Mississippi School of Medicine and the Veterans Administration Hospital and the Department of Pathology, Veterans Administration Hospital.

not appearing acutely ill. Abdominal examination revealed no palpable organs, masses, or tenderness. The remainder of the physical examination was within normal limits.

Routine admission laboratory determinations were reported within normal limits. Liver function studies revealed a total bilirubin of 1.6 mg. per cent with a direct bilirubin of 0.7 mg. per cent; BSP retention of 5.7 per cent at 45 minutes; total serum proteins of 6.3 mg. per cent with 4.3 mg. per cent albumin and 3.0 mg. per cent globulin; alkaline phosphatase 7 King-Armstrong units; first stage prothrombin time of 93 per cent; and SGOT of 21 units. Chest x-ray was normal. An oral cholecystogram revealed cholelithiasis and an intravenous cholangiogram with laminagram of the common bile duct demonstrated choledocholithiasis. An upper gastrointestinal series was normal.

Following admission evaluation by the medical service, the patient was transferred to the surgical service for cholecystectomy and common duct exploration. On April 7, 1967, an exploratory laparotomy was performed. Multiple stones were palpated in the gallbladder. A routine cholecystectomy was performed and the common duct explored. Multiple small stones were found in the duct and removed. Dilators as large as No. 6 Bakes were passed without difficulty. Diffuse induration of the head of the pancreas was noted on palpation, denoting the presence of chronic pancreatitis. A T-tube was inserted in the common duct and the cholangiogram demonstrated good passage of the contrast medium into the duodenum. A freely movable mass in the lesser sac was palpated during routine abdominal exploration. The mass was multinodular, irregular, and attached to the tail of the pancreas.

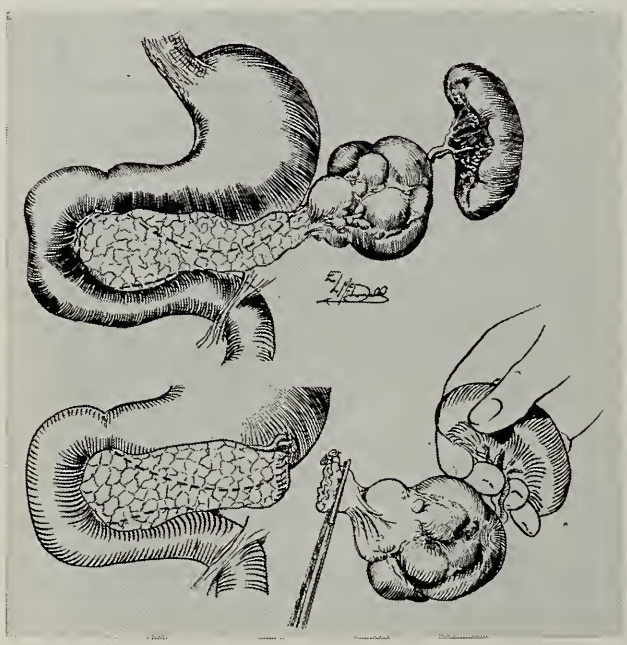


Figure 1. A. Drawing showing the location of the tumor in the tail of the pancreas and its relationship with the splenic vessels. B. Distal pancreatectomy with the attached mass and splenectomy as performed in this case.



Figure 2A. Gross appearance of the tumor demonstrating the lobulated solid characteristic and the honeycomb structure of the cut surface.

A distal pancreatectomy and splenectomy were performed for excision of the mass (Figure 1). Frozen section diagnosis was benign cystadenoma. The patient's postoperative course was uncomplicated except for a slight elevation of the serum amylase with no symptoms of pancreatitis. After the serum amylase level returned to normal, the T-tube, which had also been used for pancreatic duct decompression, was removed. The patient was discharged two weeks after the operation in good condition.

PATHOLOGICAL REPORT

The encapsulated mass weighed 246 gm. and measured roughly 10 cm. × 13 cm. × 5 cm. The capsule was glistening gray-white. Numerous small

bluish nodules were visible thru the capsule. At the base, pancreatic parenchyma was attached measuring roughly 4 cm. × .5 cm. Sections through the tumor showed a honeycombed mass. Fibrous branching strands were subdividing innumerable locules or cystic spaces, which were filled either with a clear yellow or thin brownish fluid or blood. There were foci of calcification (Figure 2).

SECOND SPECIMEN

The second specimen was a segment from the tail of the pancreas measuring about 11 cm. long, 4 cm. in width and weighing 65 gm. The distal end showed pancreatic parenchyma and what appeared to be a distended duct. No essential abnormalities of the lobulated pancreatic tissue were found.

On microscopic examination (Figure 3), sections showed a multiloculated tumor. The locules varied in size. Some were widely cystically distended and filled with a serous fluid. They were

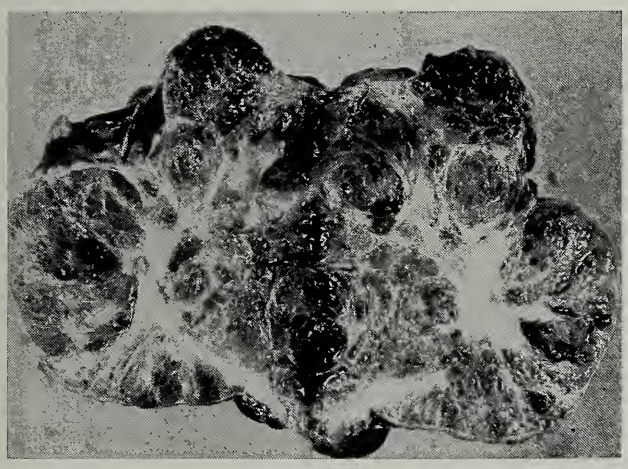


Figure 2B. Gross appearance of tumor, also illustrating characteristic and structure as shown in Figure 2A.

lined with a low or high columnar or cuboidal epithelium which occasionally formed small papillary excrescences into the lumina. Dense fibrous septa subdivided the growth. At the base, islands of pancreatic acini, ducts and occasionally island of Langerhans were scattered within the fibrous stroma. The tumor was originating from pancreatic parenchyma. At the site of the origin of the mass islands of cyst-like distended ducts were seen within the adjacent pancreatic parenchyma. Nowhere was there any evidence of malignant transformation. Sections from the separately submitted remnants of pancreatic tissue were essentially normal.

Diagnosis was cystadenoma (multilocular) of tail of pancreas. Pancreatic parenchyma (from

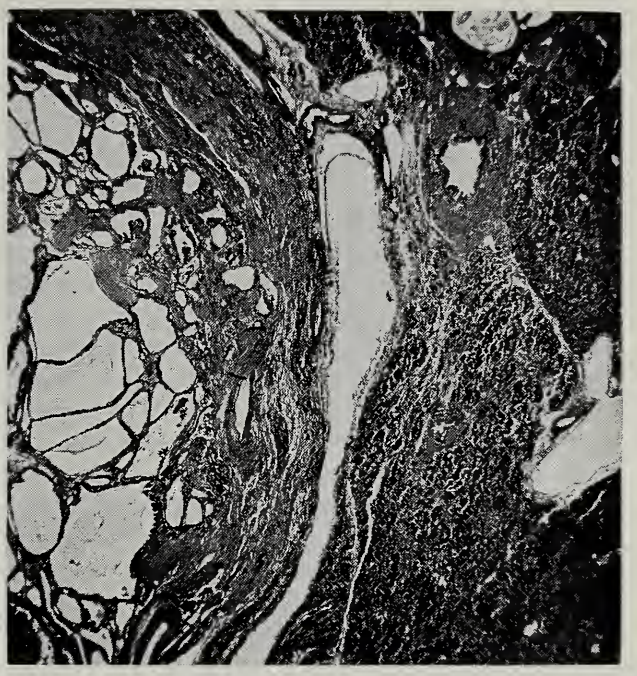


Figure 3A. Low power microscopic view of the limited area between the tumor and normal pancreatic tissue. A fairly clear demarcation is evident.

region of tail) was essentially normal. There was chronic cholecystitis and adhesive pericholecystitis and cholelithiasis. The spleen showed arteriosclerosis (severe).

COMMENTS

The lack of symptoms as well as the predilection for the body and tail of the pancreas makes this type of tumor difficult to diagnose pre-operatively. Usually they are either discovered at operation or misdiagnosed. A wide variety of preoperative diagnoses are found in the cases reviewed by Becker *et al.*[3]

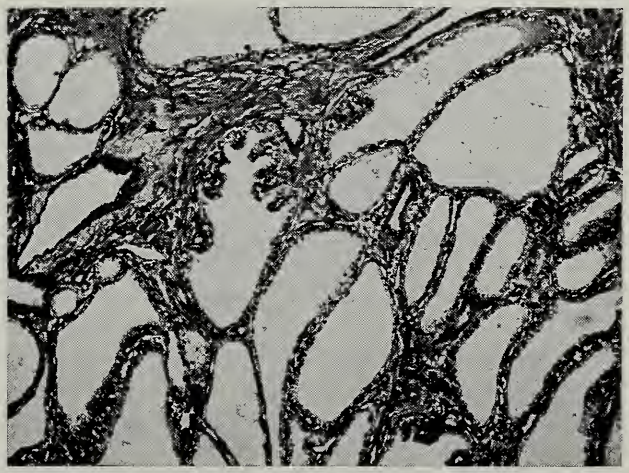


Figure 3B. The glandular pattern of the tumor is entirely benign with occasional glands showing small papillary projections.

Only a few cases were diagnosed as pancreatic tumor and in these the tumor occurred at or near the head of the pancreas. Fortunately these slow growing tumors[4] are benign and remain so for a long time, as long as nine years, as proved by serial biopsies in cases in which the tumor was predominantly cystic and the lesion was drained to the outside. However, the papillary type is believed to become malignant. Regardless, the tumor should be removed whenever possible. We believe that it is a good policy to take a biopsy of the wall of any cyst of the pancreas to determine its etiology since some cystadenomas may simulate pseudocysts by obliterating the pancreatic duct and permitting its distal portion to dilate forming a cyst.

A case of benign pancreatic cystadenoma incidentally found during laparotomy for chronic cholelithiasis is reported. Among 22 pancreatic pseudocysts, this was the only case of cystadenoma recorded at the University or Veterans Administration Center in Jackson, Mississippi. ★★★

2500 North State St. (39216)

Supported in part by USPHS Grant AM-05122-06.

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"SOMEBODY UP THERE . . ."

It was one of those occasions when the highway patrol was engaged in selected enforcement, equipped with helicopters and extra patrol cruisers. The helicopter patrolmen would observe the speed of cars over a measured mile and radio information to the ground units on violators.

An elderly priest was driving along over the speed limit, and a patrol car popped out from a side road and stopped him. As the officer prepared to give him a summons, the priest asked: "How did you know I was speeding?"

Without looking up from his ticket, the patrolman replied, "Why, the man up there told me, Father."

"My, my," was the response from the bewildered priest. "I always thought I was on *His* side."

The Fear and Rage In Sexual Deviation

RALPH SLOVENKO, LL.B., Ph.D.
New Orleans, Louisiana

EVEN IN THIS ERA of sexual freedom, homosexuals and other sex deviates are highly despised. One poll reports that two out of three Americans regard the homosexual with disgust and hatred. The majority favor legal punishment for homosexual acts even if performed in private. They feel that homosexuality is more harmful to society than adultery or abortion.

We might ask: what is it that arouses such high feeling of hate and antipathy—in them and in us? We answer: they stir us up, and they are often destructive. The public is concerned about homosexuality and other sex deviation for good reasons, irrational or not:

(1) The sex deviate reminds us of our own struggle for psychosexual identity, and how tenuous that hold is, and that makes us anxious. We are like other people, to some measure or other, and we do not like to see those aspects which we would like to put out of mind. The most stable individual may be able to regard the deviant with tolerance in a live and let live policy, but persons who are themselves precariously balanced may find the very thought of effeminancy in other males quite unsettling (the more so in a culture like the United States where the male, deprived of a patriarchal position, is especially sensitive about his maleness). It is threatening to see a member of one's profession in trouble, e.g., or to go to a funeral. We think, "There but for the grace of God, it could have been me." To put into question one's psychosexual identity provokes far more anxiety and tension.

(2) Still others may object to the homosexual and other sex deviates not out of fear to their sense of identity but rather, out of impatience with the paranoid trends of these often "angry young men." Homosexuality and paranoia have a high incidence of correlation. The aggression or hatred sensed in the sexual deviate is a prime factor causing "normals" to be so rejecting of them, and nothing is more annoying than the homosexual or other deviate who not only fails to apologize for his hostility but with a "chip on his shoulder," asserts that he belongs to a superior race. It is an illusion to say that a homosexual or other deviate is different only in his sexuality. Sexual confusion or homosexuality may easily result in violent aggressive behavior. The sex deviate is dangerous because he has little regard or consideration for others and is apt to express his anger against them. He is more than neurotic; he is closer to psychosis.

Society's condemnation of the sex deviate is not really for his sexuality but for other reasons, i.e., for threatening our sense of identity and for his hate, writes the author. He may show his hate by failing to observe the ordinary amenities of decent conduct or by committing all forms of antisocial behavior, he states. Prof. Slovenko, who holds the first joint appointment of the University of Kansas School of Law and the Menninger Foundation, has published 13 books and over 60 major articles on law, psychiatry and philosophy.

Hypotheses about the cause or causes of sexual deviation have ranged from organic-genetic theories to intrapsychic or interpersonal formulations. But however plausible the suggestion may be that some forms of sexual deviation can be accounted for either by constitutional or by im-

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Of counsel, Mouton, Roy, Carmouche and Hailey, New Orleans, La.

mediate precipitating factors, the risk is considerable that by emphasizing these aetiologies, especially when generalizing, more elaborate endopsychic developmental factors may be neglected. No one today would seriously suggest sterilization as the panacea for homosexuality. The hunchback's imperfections are hereditary, but not so homosexuality. It is the result of developmental factors of a psychological nature. It may be oversimplification to attempt to reduce the aetiology of perversions to a single factor or unitary theory, but the element of hate appears to be the most consistent underlying dynamic.

In child development the learning of basic trust is fundamental and leads to an integrated sense of self. Persons who have not developed during the early years of childhood and adolescence a sense of identity and self-worth do not grow into mature, trusting adult personalities. The individual without a sense of ego integrity is unable to rely on himself. As a result, he relies unduly on others, although he cannot trust them, and he imposes impossible burdens. He taxes beyond endurance any interpersonal relationship.

DENIGRATION OF ACTS

A person may perform the greatest act *(e.g.,* climbing the highest mountain or writing a best seller), but subjectively, the person may pollute or denigrate the accomplishment, because of his inner feeling of worthlessness. An accomplishment is not worth much to an individual when it is the product of a conflict-ridden ego or a reaction formation.

Modern-day social forces add to the difficulty of man's struggle to be a man, objectively as well as subjectively. Disruptive stresses are placed on family life, causing it to break up, to the detriment of the child. Modern society except perhaps in athletics makes it more difficult for man to display prowess and potency. It tends to reduce human beings to numbers and to instill feelings of unimportance and impotence. Primitive man performed all sorts of feats, giving him a sense of accomplishment; modern technology on the other hand, while it has conquered nature, has tended to give contemporary man a sense of smallness and insignificance.

Accomplishment or "getting up in the world" —socially and sexually—is the sign of a man. As one popular song says, "It's the same old story—a fight for love and glory." Crawling on all fours is surely not an heroic posture. Thus, the snake, crawling on its belly, offends the sensibilities, whereas the drake, cock and rooster, strutting and posing vainglorously, represent royalty. They are "king of the roost." The more upright—the more man gets off the ground—the more we admire him. A speaker who leans on a lectern is not as compelling as one who stands erect and unsupported.

HEIGHT SYMBOLISM

Unlike getting off the ground, going underground is unbecoming to man. The attributes of a bird are totally more appealing than those of the worm. Going into a subway or a bomb shelter lowers the dignity of man. The coal miner—and even the man who went "20,000 Leagues Under the Sea" (as Jules Vernes fantasied it)—are not hero-ideals. On the other hand, Icarus, while a fool, is an ancient hero, and nowadays spacemen are idolized. In the circus the trapeze artist is traditionally admired and received by an attractive girl waiting below.

Being a man means being up. A child is dependent; an adult is up. Willie Loman in *Death of a Salesman* bewailed, "A man can't go out just the way he came in. He's got to amount to something." Upness and maleness go together. You call a person *up* before you call him *down;* you do not hit a person who is down. While being up has its perils, it is the way to reward.

In the sexual sphere, a man to be a man must have the power of erection. Phallic symbols are found among man's artifacts around the world. The high rising campanile on the University of Kansas campus, for example, is commonly known among students as the "chancellor's erection." We give a fountain pen to boys on graduation and a big fat cigar to adults. Napoleon gave encouragement to his troops when he said to them, "There's a general's baton in every private's knapsack." Man says that he is "over the hill"—finished—when erection is beyond him.

MEANING OF INADEQUACY

An erection, of course, has most significance in the company of a woman, and a male unable to achieve this feels low indeed. He is not a man of nature. Sexual inadequacy is frustrating and frustration breeds hostility. The frustration is of the first magnitude. The great rationalists say that reason is the essence of man and that reason prevails over emotion, but curbstone conversation really expresses what we all really know and feel—what is below the belt controls what is above it.

Superfluously, to quote one biology professor, we may say, "Loving intercourse surely must be,

for most of mankind, the most deeply religious experience they will ever have." Odd as it may sound, it requires a sense of identity, a feeling of strength, to tolerate the loss of sense of self—of disintegration and dissolution—which occurs in the coital act.

In one sense, a man is on trial in a sexual situation. His protesting sincerely that he loves or desires his partner may have little moment if he cannot produce the physical evidence, and the more he worries about a possible difficulty, the more likely it becomes that this difficulty will arise. A man cannot command his own erection. On the other hand, a woman, owing to the nature of her anatomy, can permit intercourse even though she is frigid and not in the least interested in it. Anatomy, Freud said, is destiny.

To withdraw is to play it safe, but human contacts affirm who we are and give meaning to life. Withdrawal is miserable, but it may be the best that a person can do. Perversions are not praiseworthy, but they may be a person's only resource to give him a sense of self and to contain his unconscious aggression or sadism. It is his way of achieving a "vital balance," to use Karl Menninger's term, and keeps him on his "rocker," although it may not be a very good one. A perversion may be a problem, to the individual and to others, but it may ward off further and more serious problems.

DEVIATE'S COMMUNICATION

Too much stress may cause an individual to withdraw completely into a world of his own or into a monastic life. The sex deviate, while he may be angry, is still trying to maintain some sort of contact with other people. Incapable of a heterosexual relationship, he may settle for a homosexual relationship. The homosexual position may provide his only bridge to the outside world. Unlike other perverts, the homosexual maintains a contact with another person. Generally speaking, exhibitionists, voyeurs and fetishists are more frightened than the homosexual of an emotional rapport with another person. The exhibitionist represses great unconscious fears, and he eliminates the feared danger of attack by keeping the sexual objects of his sadism at a distance. The exhibitionist may be unable to get even this "close" to a woman, and so instead, finding it less threatening, he exhibits himself to a minor.

Like the exhibitionist, the voyeur is an inhibited individual. Indecent exposure and peeping are the marks of sexual inhibition. As one voyeur put it, "I'm bashful, I don't know what to say to a girl. When a girl wants to go out with me, it scares me to death. I'd rather face a den of lions than one woman."

Homosexuals who are highly inhibited look for a partner in a bar or in a toilet. The meeting is fleeting. In effect, he is saying, "Anyone will do." Sometimes, the other is not even seen, as when a stranger is fondled under a toilet partition wall or through a hole in the wall.

COMPULSORY INHIBITION

An essential element in shyness is the lack of trust in other people and in their interpretations of the world. It results in inhibition that is not volitional, but compulsory, of being an outsider. One who is anxious needs distance. In a classroom, for example, a desk separates teacher and students, and outside this or other formal structure, some teachers and students are unable to get together. They "prefer" to learn exclusively through books. Intense intellectual activity, in apparent devotion to the pursuit of abstract truth, is sometimes the expression of a mental disorder, rather than the wholesome activity of a well-balanced personality.

Some people's interest in animals is a result of moving away from people (they may go into "animal husbandry"). In these cases, the interest in animals represents an attempt to hold on to something that is human. It is an attempt to have some kind of relationship. Animals are "lovable" and "will not bother a person unless bothered first." All of these patterns of behavior may be the result of the individual's distrust of others and his expectation of being hurt in an interpersonal contact.

Man and woman form a unity. The relationship provides for the greatest closeness, hence it may be the most rewarding and the most threatening of relationships. An old Jewish expression says, it may be hell with a woman, but it is double hell without one. Like Edward Albee's George and Martha, apparently even destroying one another by bits and pieces is more desirable than aloneness. Hate is not at the polar opposite of love—it is in between love on one end of the scale of human relations, and despair on the other end (to hate you have to care). The ancient Greeks taught that the most horrible of ills is not dying, or knowing about dying, but dying alone.

RELATIONSHIP CHARACTERISTICS

The heterosexual relationship best serves to meet dependency needs and to integrate and neutralize aggressive drives. Homosexual activity is often regarded as being performed for orgastic pleasure whereas this may be insignificant. In-

deed, actual sexual activity or stimulation may be rather rare. The mutual dependency among homosexual partners, which is often intense, may be far more important than sexual activity. To depend requires trust, yet the basic distrust observed in homosexual relationships is so prominent.

Violent disturbance occurs during the breakup of a homosexual partnership, perhaps not so much because of the loss of affection, or because of the loss of an orgastic outlet, but primarily because it is rather a confirmation of their worst and continual fears that no one is to be trusted, that is, what existed before was not affection and loyalty. The breakup is more devastating than the worst of husband-wife quarrels and the hostility is not localized toward the partner. The hate is extended or transferred to other persons.

The "gay" or happy homosexual is a myth. The stresses and strains on his psychic apparatus do not permit tranquility. The gayness is like the circus clown's happiness—a reaction to sadness and depression. Woefully alone, he becomes increasingly narcissistic and paranoid. As he goes through life, he gathers more and more evidence that he cannot trust himself or others. His hate mounts, and hate evokes hate. He is always collecting "injustices" against him.

We rely on our identification. It is sad when our identification makes us all alone. Men or women when deprived of the satisfaction, respectively, of masculinity or femininity and the intimacy of a heterosexual relationship become hateful. The hate is expressed in all forms of cruel acts, both in and out of the family. The frustration-aggression hypothesis of the learning theorists says that frustration is a necessary (but not sufficient) condition for aggression; the inability to relate with a person of the opposite sex serves as a frustration of the first magnitude.

The person who has not learned love and trust, and can see only hate, or mostly hate, may in alienation turn back upon himself in depression, or he may explode in violence and anger against others. Shakespeare's celebrated words in Hamlet are well remembered:

> To be, or not to be: that is the question:
> Whether 'tis nobler in the mind to suffer
> The slings and arrows of outrageous fortune,
> Or to take arms against a sea of troubles . . .

CONCLUSION

The homosexual and other sex deviates, angry individuals, feel that they have been cheated, they do not know who they are, and they do not feel any sense of confidence. The condemnation of the sex deviate is not really for his sexuality but for other reasons—namely, for threatening our sense of identity, and for his hate. He may show his hate by failing to observe the ordinary amenities of decent conduct (by performing homosexual acts in public restrooms) or by committing all forms of antisocial behavior. ★★★

225 Baronne St. (70112)

QUIET, PLEASE

The young mother, visiting her physician, made absolutely no attempt to restrain her four year old son who was enthusiastically engaged in making a shambles of the adjoining treatment room. A loud crash prompted her to say: "I hope, doctor, that you don't mind Bobby's curiosity."

"Not at all," the physician assured her. "I'm sure he'll be quiet in a minute when he gets to the poisons."

Clinicopathological Conference XC

Conducted by the Department of Pathology
Mississippi Baptist Hospital
Jackson, Mississippi

A 60-YEAR-OLD, COLORED woman was admitted to the Baptist Hospital for the first time in November 1959, with the chief complaint of pain in the right flank. The pain began five days prior to admission and was described as gnawing in character. She also complained of nocturia. She had had occasional nausea accompanied with vomit of clear fluid and had lost some weight during the past month. A similar attack of pain had occurred about eight months previously.

Physical examination, except for moderate tenderness in the right flank and a blood pressure of 162/110, was within normal limits. Blood WBC and hemoglobin were normal. Urine examination showed a 3+ albumin, 2-4 WBC/hpf, and no red cells. Serum BUN was 27.8 mg. per cent. VDRL was negative. X-ray examinations of the chest and gallbladder were negative. An upper GI series revealed a small ulcer on the lesser curvature of the stomach just above the angle. An IVP study showed a normal filling on the left; on the right the kidney architecture was not well seen, but marked obstruction was not suggested and the ureter was not seen well enough for comment. No organisms grew out from the culture of the catheterized urine.

Her second admission was on September 24, 1961. Her main complaint at this time was fever and backache of about 10 days' duration. In addition, she had nausea, vomiting, weakness, and pain in the left cervical region. At this admission it was stated that myasthenia gravis had been diagnosed in the past but no further mention of it was made.

On physical examination, soreness on left cervical region was noted and an apical systolic murmur on the precordial region was heard. Blood pressure was 168/90; pulse and temperature were normal. The hemoglobin was 12.5 gm. per cent and the WBC 5,900 with 84 segmenters. The urine examination showed a specific gravity of 1.017, 3-4 WBC/hpf, no red cells and no protein. The patient was discharged on the third day of hospitalization.

She was admitted for the third and last time on December 2, 1966. During the interval she had been seen by the urologist for her renal condition diagnosed as pyelonephritis and by the internist for evaluation of an anemia. During this time she had also complained of severe joint pain which was attributed to arthritis and treated accordingly.

The patient in CPC XC is a 60-year-old Negro woman who was admitted initially with a complaint of pain in the right flank. Complaints on subsequent admissions included fever and backache, vomiting, weakness, pain in the left cervical region, and severe joint pain. Diagnoses mentioned in the protocol were myasthenia gravis and pyelonephritis. Discussers are Drs. David J. VanLandingham and Louis Schiesari.

On admission she complained of tiredness, weakness and dizziness. The blood pressure was 220/120. Temperature, respiration and pulse were normal. There was mild tenderness in the epigastrium and some enlargement of both knees, with pain on extreme flexion and extension, and also limitation of motion in both hips. The patient appeared confused and "toxic."

Laboratory data on admission was as follows: urine—specific gravity 1.012, albumin 1+, sugar 0, WBC 5-6/hpf and rare RBC; blood—WBC 6,800 with 83 segmenters, hemoglobin 7.9 gm. per cent. Blood glucose on three successive examinations was 37, 35, 43 mg. per cent. Total serum protein was 7.3 gm. per cent, globulin 3.4 and albumin 3.9 gm. per cent. Alkaline phosphatase

was 3.4 BU; chlorides 113 mEq.; potassium 5.8 mEq.; sodium 146 mEq.; urea nitrogen 136 mg. per cent; creatinine 10 mg. per cent. Chest x-ray revealed clear lungs and moderate left ventricular enlargement.

The hypoglycemia was corrected with intravenous administration of glucose. The patient remained afebrile, was occasionally drowsy, but in spite of a rising BUN and creatinine, 222 and 14 mg. per cent respectively on December 16, 1966, it was stated that the patient did not show particular signs of uremia. The urinary output was adequate. On December 15, 1966 the blood pressure was 140/90. On December 26, 1966 her condition began to deteriorate rapidly with steady dropping of the blood pressure. The creatinine rose to 16 mg. per cent and the BUN to 243 mg. per cent. Numerous rales were heard in both lung fields. The patient lapsed into coma and expired 28 days after admission.

Dr. David J. VanLandingham: "You have the protocol in front of you, and since our time is short, I will not take the time to read it in its entirety. I will instead call your attention to the pertinent factors as I see them. The first would be her blood pressure of 220/120. She was apparently running consistently high blood pressure, getting higher all the time. Temperature, pulse and respiration were normal. I call attention to this in view of a later consideration of pyelonephritis. There was slight tenderness in the epigastrium and an enlargement of both knees was present. There was pain on motion of her knees and there was limitation of motion in her hips. She was confused and toxic on admission.

LABORATORY STUDIES

"The positive laboratory studies revealed a urine with a specific gravity of 1.012 and an albumin of 1+. There were 5 to 6 white cells and rare RBCs but no casts. She had a marked anemia with a hemoglobin of 7.9 gm. An important and intriguing finding is the consistent low fasting blood sugar of 37, 35 and 43 mg. per cent. The total protein and AG ratio were slightly off and with the globulin being a little higher than the albumin. The BUN was quite high on admission, 136, and rose progressively to 243. The creatinine was also elevated, being 10 mg. per cent on admission, rising progressively to 16. The x-ray of her chest showed only moderate left ventricular hypertrophy.

"There is a suggestion that this patient had pyelonephritis. I would like to know what her urine showed between 1961 and 1966. Was there really pus in her urine? Just how much of an abnormal urine did she have? There is an interesting statement that the urine output was 'adequate.' To me this is a misleading statement. If she was developing a progressive uremia, I would suggest it was not adequate. It might have been a sufficient quantity but certainly was not adequate in its concentrate or else she would have been clearing her uremic substances rather than accumulating them.

MULTIPLE DISEASE PROCESSES

"It is customary to try to blame all symptomatology on one disease process. Yet, I have done enough pathology and have seen pathologists' reports enough to know that it is extremely unusual to find a single disease process that will explain all findings. There are usually multiple abnormal findings and I expect this to be the case here, but I will try to explain all the above abnormal findings on one disease process if I can.

"May I run down a list of differential diagnoses. First, I would consider some generalized systemic disease, such as periarteritis or polyarteritis, that would give multiple infarcts producing pain. This disease can last over a period of many years. Nearly always an abnormal urine is cause of infarctions in the kidneys. Infarctions of the spleen also are common and account for the left upper quadrant pain. Infarctions of the liver can also occur though they are unusual because of the dual blood supply. Periarteritis or polyarteritis is nearly always associated with some degree of arthralgia or arthritis. An elevated blood pressure is likewise more often seen than not. One important finding of polyarteritis, however, is a leukocytosis which is missing here. There is usually also an eosinophilia which is not present here.

"A second similar disease is lupus erythematosus disseminatus. Again the same thing occurs here although high blood pressure is not as common but there is an abnormal urine, arthralgia and multiple systems involvement. Neither of these diseases, however, would explain to me satisfactorily the hypoglycemia described above nor the gastric ulcer. I feel sure gastric ulcer is an incidental finding, but I have a strong feeling the hypoglycemia is a significant clue.

"Subacute bacterial endocarditis must always be suspected where there is a heart murmur and a murmur was present where fever is reported. It was reported at least once. In this instance also an abnormal urine is quite common. Embolic phenomenons also are common and might produce symptoms anywhere. An arthralgia or arthritis would not be as common but might occur. Again

hypoglycemia would be difficult to explain on the basis of subacute bacterial endocarditis.

"Renal vascular disease might explain the hypertension and the abnormal urine and the renal failure, but I find it difficult to explain the arthritis, the hypoglycemia and the gastric ulcer on the basis of renal vascular disease.

"Myasthenia gravis I mention only in passing because of her marked weakness. This is due to an abnormality of the breakdown of acetocholine at the myoneural junction and could not in any way, so far as I can see, produce the high blood pressure, the abnormal urine, the marked anemia and abnormal pain.

"Pyelonephritis has been mentioned, and it certainly can explain the hypertension and abnormal urinary findings. I would expect more fever in an infection that is this destructive, but fever is mentioned only once. Pain would not be typical of pyelonephritis nor would the arthralgia or arthritis nor the hypoglycemia.

"I could now come to a consideration of some sort of a tumor, either of the pancreas or an extrapancreatic tumor. A tumor of the pancreas may involve the islets cells themselves giving rise to hyperinsulinism, and this tumor may be malignant with metastases explaining some of the other symptoms of pain and anemia. In many cases of metastatic disease there are arthralgias. It is more commonly seen in tumors of the lung.

"There are other tumors besides islets cell tumors that produce hypoglycemia. I have just reviewed, at the University Library, an article which describes and lists 18 different kinds of tumors of extrapancreatic origin associated with hypoglycemia. Three of these were of the adrenal cortex, several were retroperitoneal tumors.

"At a recent convention of the American Dietetic Association in Dallas, a group was reviewed in which there were 50 fibromas, sarcomas and fibrosarcomas, most of which were retroperitoneal, either in the thorax or abdomen. There were 29 hepatic carcinomas, 13 carcinomas of the adrenal cortex, 5 carcinomas of the GI tract and 2 bronchogenic carcinomas associated with hypoglycemia.

NATURE OF TUMOR

"I am inclined to believe that this is an extrapancreatic tumor, probably malignant and probably residing in the adrenal cortex. Most of the extrapancreatic tumors involved with hypoglycemia reported have been massive tumors but not necessarily large. Some have been small tumors involving glandular activity. I believe an adenocarcinoma of the adrenal cortex might best explain the symptom complex reported above which includes hypertension, abnormal urine, abnormal intravenous pyelogram, hypoglycemia, severe anemia, pain in various places and the arthritis and progressive uremia leading to death. Such a tumor might conceivably explain the gastric ulcer due to its increased steroid secretion. The next best possibility in my explanation would be a collagen disease such as polyarteritis or lupus. I am anxious to hear the pathological report."



Figure 1

Dr. Louis Schiesari: "Dr. VanLandingham was right in concluding at the end of his excellent discussion that the culprit in this case was a tumor, although of a different nature from what he suspected.

"At autopsy, upon extending the primary incision to the neck for the routine exploration and removal of the thyroid gland, I found an egg-shaped, tannish-brown, smooth nodule measuring 1.8 cm. in length and 0.8 cm. in diameter. This nodule was close, but not attached, to the lower pole of the right thyroid lobe. The kidneys weighed 80 gm. each, had a granular outer surface and a completely effaced cut surface. Several sections of bone from vertebrae, sternum and ribs were taken.

"The first slide (Figure 1) shows a far-advanced alteration of the renal architecture: a diffuse fibrosis replacing the renal corpuscles and tubules with a number of the surviving tubules being quite distorted. There was no inflammatory reaction and

no calcification. In conclusion, it was not a pyelonephritis, which most of the time is a misnomer, but a pure nephrosclerosis where the tubules and interstitial tissues are primarily involved while the vessels and renal corpuscles are only secondarily affected; this is said to be a change characteristic of the hyperparathyroid nephropathy.

"The next slide (Figure 2) is from a vertebra and shows deep indentations along a trabecula with a pronounced fibroblastic proliferation in the attempt to replace the lost bone. Most of these cells remain collagenoblasts, very few reaching the stage of the osteoblasts, so that in the end the osteoclasts have always the upper hand. This microphotograph is one that shows the most advanced changes. In general, on microscopic examinations of many sections, there was only a mild loss of bone substance from the trabeculae; it was a diffuse but mild osteoclastic process which explains the absence of bone changes on the x-ray films.

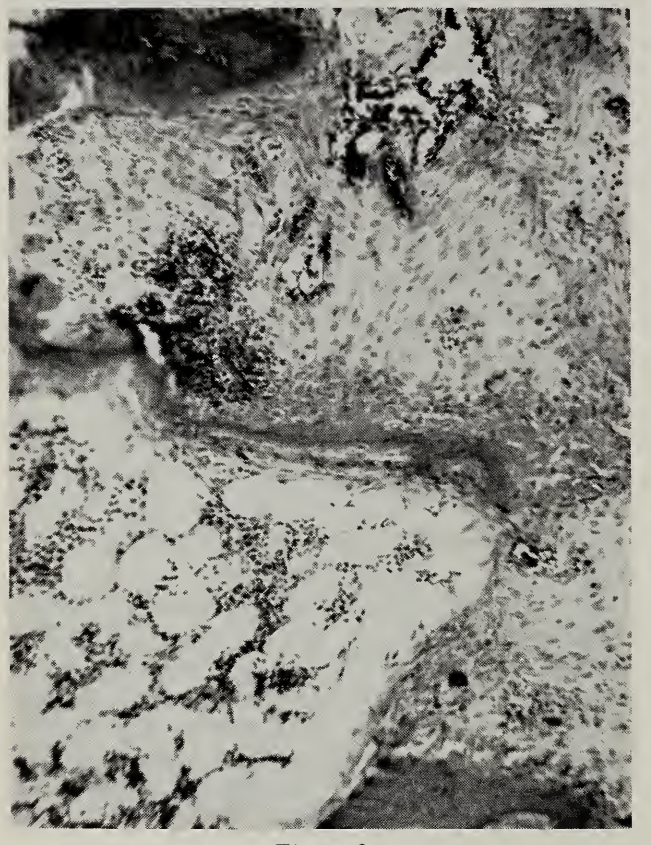


Figure 2

"The next slide (Figure 3) is a section of the nodule. Three elements are necessary to make a diagnosis of a true adenoma of the parathyroid gland, and here we have all these three elements: a rim of normal parathyroid tissue slightly compressed at the periphery, a narrow band of collagen tissue forming the capsule, and inside, the adenomatous tissue composed of chief cells; hence, a chief cell adenoma of the parathyroid gland,

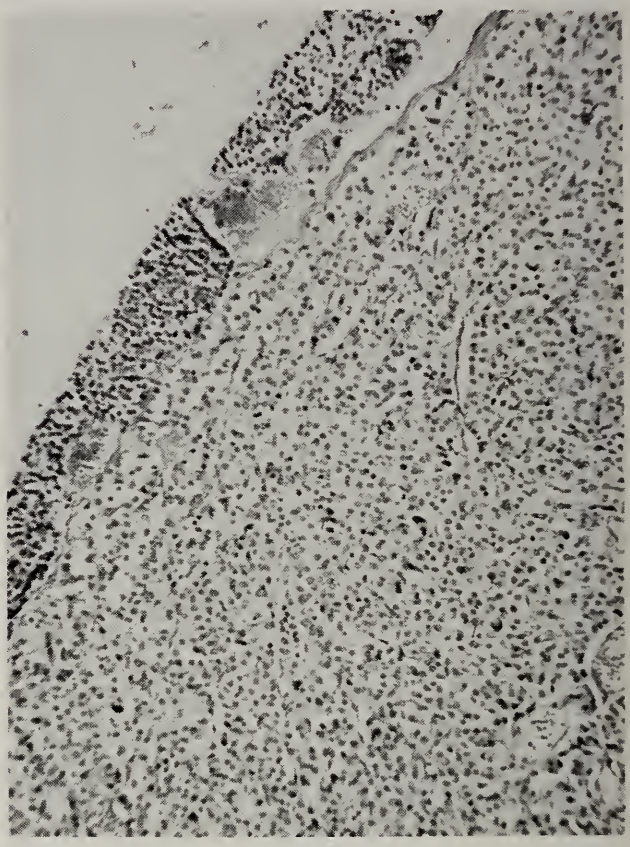


Figure 3

solid type. In another section there is represented a follicular type from the same nodule. This type is most important for the pathologist since it is difficult if not impossible to tell it apart from a thyroid adenoma.

"Forty-two years ago when the first parathyroid adenoma was removed, all we knew about hyperparathyroidism was that it caused fibrocystic disease of bone, also known under the name of von Recklinghausen disease. Our knowledge of the subject since that time has widened, and we now know that a number of clinical and pathological manifestations are related to hyperparathyroidism.

"In Table 1 there is a list of such manifestations, most of which, I am sure, you are already acquainted with. Some new light has been thrown in recent years in the relationships between the parathyroid hormone and the pancreas. The parathyroid hormone and the glucagon are antagonists, the glucagon tending to lower the hypercalcemia of hyperparathyroidism but not that from other cases such as metastatic carcinoma or sarcoidosis.

"In chronic pancreatitis the tissue concerned with the exocrine portion of pancreas is more or

less destroyed and replaced by fibrous tissue. The islets of Langerhans, however, are well preserved and show hypertrophy and hyperplasia of the glucagon-producing alpha cells. An increase of this hormone in the plasma has been established in the chronic pancreatitis. The parathyroid glands increase the level of the parathyroid hormone through hyperplasia or multiple adenomas in order to counteract the hypocalcemic action of the glucagon. On the other hand, in primary hyperthyroidism there is increase of glucagon secretion accompanied by marked hyperplasia of the alpha cells of the islets of Langerhans, as a mechanism to prevent marked rise of serum calcium.

"In the past few years the relationship between hyperparathyroidism and joint disease has provoked the publication of a good number of articles on this subject. Our time is running out, and it is impossible to go through this in detail. Suffice to say that in hyperparathyroidism there is a true gout with urate crystals deposition in the joints and increased uric acid in the serum. This is ascribed to the fact that hypercalcemia interferes with tubular uric acid secretion. The chondrocalcinosis of hyperthyroidism is indistinguishable clinically and pathologically from the idiopathic type since both are characterized by deposition of calcium pyrophosphate crystals in the joints. The only difference is that in idiopathic chondrocalcinosis the calcemia is normal. I put subchondral erosion between parenthesis because although this is an arthropathy, actually it is a

TABLE 1

Peptic Ulcer	
Pancreatitis	
Fibrocystic Osteitis	
Nephropathy	nephrocalcinosis
	nephrosclerosis
Arthropathy	arthralgia
	effusion
	chondrocalcinosis
	gout
	(subchondral erosion)

result of the fibrocystic osteitis which had involved the bone plate supporting the joint.

"In conclusion, this case of hyperparathyroidism was characterized by absence of nephrocalcinosis, absence of visible bone changes on x-ray film and absence of hyperplasia of islets of Langerhans. About 40 per cent of cases of hyperparathyroidism fall in this category. In fact, there are two distinct forms of hyperparathyroidism, one accompanied by overt bone disease and the other

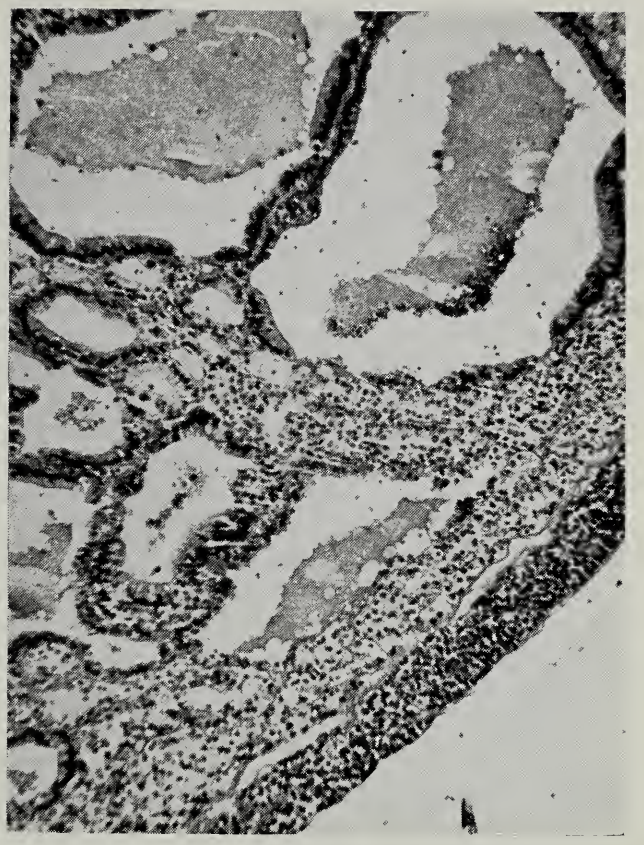


Figure 4

without apparent bone disease. We can find an explanation for these two forms if we consider a third hormone, the thyrocalcitonin, which comes into play in the clinical manifestation of the hyperparathyroidism.

"The thyrocalcitonin, the hypocalcemic principle of the thyroid gland in animals, is another antagonist of the parathyroid hormone and tends to suppress the bone resorption by blocking the parathyroid hormone activity at the bone level. Thus, in those cases in which the thyroid gland responds promptly to the hypercalcemia by increased production of thyrocalcitonin the bone absorption activity of the parathyroid hormone, if not completely suppressed, is much decreased.

SERUM CALCIUM

"In closing, I would like to remind you that the serum calcium determination, because of the great number of manifestations with which the parathyroid hormone is connected, should be done much more frequently than it is now. Second, I would like to emphasize the fact that so far the serum calcium determination is the best test available to assay the parathyroid functions. Of the routine laboratory tests, the alkaline phosphatase is not elevated in hyperparathyroidism unless there

is a massive subperiosteal absorption of bone, and the serum phosphorus is within normal limits in about 40 per cent of patients with hyperparathyroidism. Other more specific tests for the diagnosis of hyperparathyroidism such as tubular absorption test, calcium infusion test and measurement of urinary calcium content in 24-hour urine specimens are practically of no value since their results are inconstant and too overlapping, and so they fail completely when most needed for the diagnosis.

"A good differential test is represented by a week's trial with cortico-steroids. Absence of modification of calcemia indicates primary hyperparathyroidism and permits the elimination of the other causes of hypercalcemia as sarcoidosis, Vitamin D intoxication, Burnett-syndrome, metastatic carcinoma, pseudohyperparathyroidism. Recently, three highly accurate but too sophisticated tests for the hospital laboratory have been introduced: 1. glucagon infusion test; 2. serum glucagon level by radioimmune assay; 3. scanning of parathyroids by bilateral injection of selenite-methamine 75 in the thyrocervical trunk. ★★★

1190 North State St. (39201)

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1. Zvaifler, N. J.; Reefe, W. E., and Black, R. L.: Articular Manifestations in Primary Hyperthyroidism, Arthritis and Rheum. 5:239-249, 1962.
2. Donnelly, W. J.: Hypercalcemia and Lethargy, Postgrad. Med. 41:623-629, 1967.
3. Paloyan, E., and Lawrence, A. M.: Alpha Cell Hyperplasia in Calcific Pancreatitis Associated With Hyperparathyroidism, J.A.M.A. 9:757-761, 1967.

TRAVEL—ITALIAN STYLE

A London travel agency distributes a booklet of advice to young women planning vacations in Italy. It warns: "Don't think that you can rid yourself of young Italian suitors by simply saying that you are married or that you suffer from a contagious disease. Once stimulated, they are not easily put off. If you wish to be rid of them, say something important, such as, 'I've lost all of my traveler's cheques.' "

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 16-20, 1968, San Francisco, Calif.; Clinical Convention, Dec. 1-4, 1968, Miami Beach, Fla. F. J. L. Blasingame, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

American Academy of General Practice, Annual Meeting, Sept. 13-20, 1968, Las Vegas, Nev. Mr. Mac F. Cahal, Executive Director, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

Southern Medical Association, Annual Meeting, Nov. 18-21, 1968, New Orleans, La. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 100th Annual Session, May 13-16, 1968, Jackson. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. S. E. Field, Jr., Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. William O. Barnett, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, First Monday January and July, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 668, Clarksdale, Secretary.

Coast Counties Medical Society, First or Second Wednesday, January, March, May, September, and November. C. Hal Cleveland, 3017-13th St., Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday Quarterly, Jefferson Davis Memorial Hospital, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Third Wednesday March, June, September, and December. A. Derrick, Jr., Durant, Secretary.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Oxford. M. Beckett Howorth, Jr., 2200 S. Lamar Blvd., Oxford, Secretary.

Pearl River County Medical Society, Second Monday March, June, September, and December. J. M. Howell, 215 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, Green Clinic, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Patrick G. McLain, 1301 Washington St., Vicksburg, Secretary.

Radiologic Seminar LXX: Spondylolysis

W. T. COLBERT, M.D.
Natchez, Mississippi

SPONDYLOLYSIS is defined as the lack of fusion of the pars interarticularis of the articular process of the vertebra. The change is usually seen at the lumbo-sacral joint, less often at the other lumbar joints. Its importance lies in the fact that spondylolysis is felt by most authorities to be a constant precursor of spondylolisthesis—the actual displacement of one vertebral body upon another. However, spondylolysis is frequently present without spondylolisthesis and can exist for an extended period of time without actual slipping of the vertebral body upon its neighboring vertebra.

Whether the defect in the pars interarticularis is congenital or acquired is a matter of considerable controversy. The defect may be unilateral or bilateral, and the apparent erosion of the pars interarticularis can be progressive as observed on sequential roentgenologic studies of the low back over a period of years.

Spondylolysis is frequently asymptomatic, being discovered on a routine study of the low back following a minor injury, or more commonly, on a routine pre-employment study of the lumbar spine—an examination which is being required with greater frequency by industrial organizations. Most employers consider spondylolysis a disqualifying defect, presumably on the basis of potential ease of injury or the subsequent development of spondylolisthesis.

The usual routine views of the lumbar spine, antero-posterior, lateral, and detailed lumbo-sacral spot film (Figure 1) in the lateral projection, frequently will not adequately demonstrate the defect in the pars interarticularis. It is our practice to include routine oblique projections of the lumbar spine in all examinations of the low back. The oblique films are made in the antero-posterior projection, with the patient supine, and the torso rotated 45° toward the lateral (Figures 2 and 3). These views will adequately demonstrate the defect in the pars interarticularis in all instances of

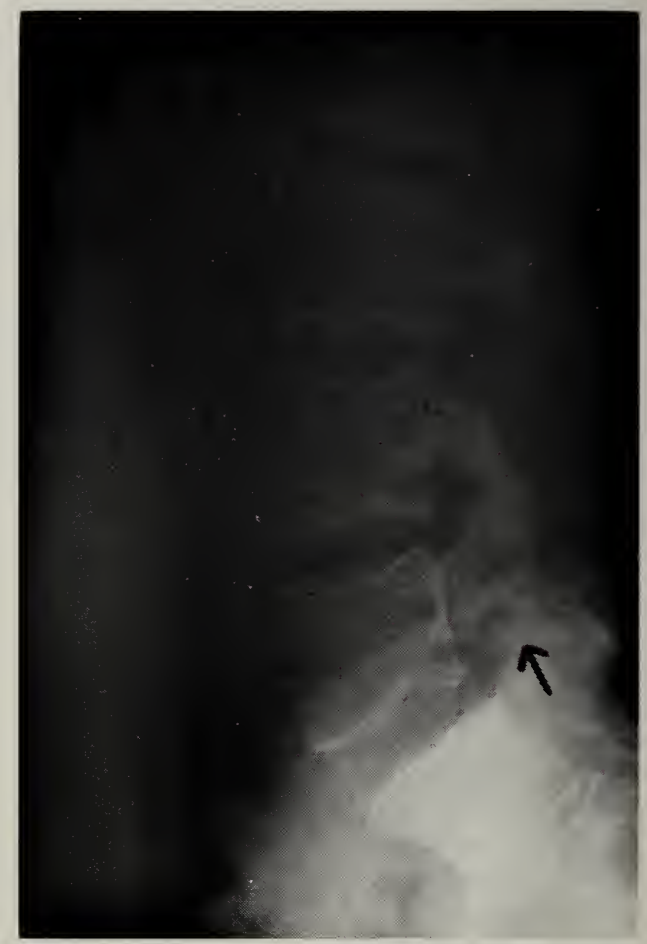


Figure 1. Routine lateral lumbo-sacral view above demonstrates suspicion of defect in one or both of the pars interarticularis. Definite diagnosis is not possible.

Sponsored by the Mississippi Radiological Society.





Figures 2 and 3. Oblique views of the low back demonstrate definite defect in the pars interarticularis at L5-S1 on the left, and a minimal early spondylolysis at L5-S1 on the right (lower arrows). Normal pars interarticularis are well demonstrated at the level just above (upper arrows).

bilateral disease and in most instances of even minimal unilateral change.

CONCLUSION

Spondylolysis is a significant abnormality of the low back, and one that is frequently not demonstrated on the usual routine studies. Oblique projections of the lumbar spine will consistently demonstrate the defect in the pars interarticularis and are recommended as a routine part of the roentgenologic examination of the low back. ★★★

Natchez General Hospital (39120)

REFERENCES

1. Epstein, Bernards: The Spine—A Radiological Text and Atlas, Philadelphia, Lea and Febiger, 1955.

TRAFFIC TIGER

And then there was the inept applicant for a driver's license. He did so badly that he got two traffic tickets during the written test.



The President Speaking

'Don't Hinder Progress'

TEMPLE AINSWORTH, M.D.
Jackson, Mississippi

THE FOOD AND DRUG ADMINISTRATION intends to put teeth in its recently acquired authorities relating to "safety and efficacy" in prescription drugs. Dr. James L. Goddard, FDA commissioner, has announced that an estimated 300 drugs, now marketed under 1,600 brand names, will be forced off the market in 1968 because of ineffectiveness for treatment of medical conditions.

In mid-1966, FDA initiated an evaluation of 3,000 drugs which had made their appearance on the market from 1938 to 1962. The evaluation is being conducted by 20 panels of about 200 medical and pharmaceutical authorities under the direction of the National Academy of Sciences and the National Research Council, both quasi-official scientific bodies supported in the main by federal funds.

These authorities were given to the FDA in 1962 following hearings by the Kefauver Committee of the Senate. While the law actually specified FDA determination of drug safety and efficacy after 1962, a provision was added permitting the agency to evaluate drugs then on the market.

Since that time, the number of new drug entities finding their way to the ethical prescription drug market has diminished substantially. The licensing of a new drug has become an arduous, long, and difficult task for the industry. To some extent, drug manufacturers have found that this long and expensive procedure doesn't always return its huge investment in research.

Everybody favors drugs which are as safe as science can make them and as efficacious as possible. Nobody denies that a formal and valid licensure procedure should be carefully maintained with reference to new drug products. At the same time, care must be exercised to make certain that the controls so exercised fulfill as precisely as possible the purpose for which they were intended and that nothing beyond this hinders the forward thrust of pharmaceutical progress. ★★★

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EDITORIALS

Medical 1967: Year of Problems and Progress

I

THE MEDICAL YEAR 1967 may be recorded as the period when more medical problems were identified than solved. This cheerless probability notwithstanding, the year did mark solid progress in immunology, biochemistry, and experimental surgery in organ transplantation. Five new medical schools were opened in the United States, and two American scientists won the Nobel Prize in medicine. Times have been better, but all in all, it was a good year.

There is a general consensus that cardiovascular disorders, chronic nontuberculous lung disease, alcoholism, drug abuse, and the dilemma of abortion are identified as outstanding health problems in the United States which urgently demand imaginative and massive medical effort.

But in the "third world" of nations making the painful transition from agricultural to industrial economies, malnutrition and infectious disease remain the major causes of morbidity and mortality. The healing hand of medical science has reached into enough of these underdeveloped areas to upset the balance between death and explosive population growth only to raise the specter of starvation.

And more than in any previous year, 1967 saw government become increasingly entrenched in the delivery of medical services as the largest single purchaser. A variety of factors interplayed on the American scene to boost the cost of medical services, notably in the hospital field, and the medical manpower problem was acutely accentuated by the rapid emergence of more government programs, growing consumer purchasing power, and the steady forward march of the science and technology.

So 1967 takes the shape of a paradox: It was a year of vexation and attainment, of problems and progress, and thrust and reversal. The Four Horsemen of the Apocalypse still ride as science grapples with the effects of war, famine, pestilence, and death.

II

In the assault on heart disease, one of the most massive epidemiological studies in medical history has been recommended by the American Medical Association. It is designed to furnish new knowledge as to possible prevention of coronary artery disease by diet and would involve the study of as many as 100,000 subjects over five years. The proposal grew out of the National Diet-Heart Study feasibility trials, a much smaller pilot project involving study of 2,400 male subjects aged 45 to 54 years over a 24 month period.

The fundamental premise for the major study, as proposed to the National Heart Institute, includes the extremely high incidence and mortality of coronary artery disease, the overwhelming evidence associating this incidence with serum cholesterol levels, and the safe lowering of the serum cholesterol level by diet modification in ways acceptable to large numbers of individuals.

Still another approach to the heart disease prob-

lem was the Coronary Drug Project which was initiated in 1967 after years of planning. It is a nation-wide cooperative clinical trial having the objective of assessing efficacy of several lipid-lowering drugs in long-term therapy in patients with previous myocardial infarction.

Fifty-five medical centers, the American Heart Association, and the National Heart Institute are working in the CDP. In the next two years, studies will be made of 8,400 male patients aged 30 to 64 years, each with histories of one or more verified infarctions.

Further progress was noted in the Farmingham (Mass.) Heart Disease Epidemiology Study, a long-term investigation of more than 5,100 adults in the area and the incidence of "silent" or unrecognized episodes of myocardial infarction. It has been discovered that one out of four attacks is unrecognized.

III

The 1967 medical success story is about vaccines, products of the profit and payoff from basic research in virology and immunology. Measles is on the way out with fewer cases reported in 1967 than in any period since the Public Health Service began records-keeping in 1912. The Merck mumps vaccine came through clinical trials involving 6,500 individuals with excellent serologic response and protective efficacy. The vaccine was licensed last month.

Researchers believe that an effective vaccine against rubella will be available in two years, based on early observations in clinical trials last year. At the University of Chicago, there is guarded optimism over the promise of the vaccine against streptococcal infection associated with rheumatic fever and certain types of kidney disease.

Progress with the vaccine to prevent erythroblastosis fetalis suggests that it may be licensed this year. It is an anti-Rh immune globulin which is given the Rh-negative mother following the birth of her first Rh-positive child, presumably setting up a mechanism of antibody-induced immunosuppression.

Investigators expressed hope that interferon may yet become a potent weapon in the clinical arsenal as an antiviral agent, and major effort is being exerted to obtain satisfactory interferon production in cultures of human cells.

The year marked advances in transplantation of organs, even though the first successful such procedure, that of transplanting a kidney, took place more than 12 years ago. The scientific journal, *Transplantation,* reports that nearly 1,200 kidney transplants have been performed and that where the donor and recipient are related, 55 per cent have survived a year or longer, but this percentage is happily increasing. This, says *Transplantation,* is the result of advances in understanding more about immunological response. A non-pharmaceutical approach to immunosuppression is the employment of antilymphocyte serum (ALS) which is coming into wider use.

The year-end drama of the Capetown heart transplants by Dr. Christian Barnard and his colleagues at Groote Schuur Hospital seems to underscore new advances in organ transplantation, although AMA cautions that "transplantation of internal organs is still a highly experimental procedure on the frontier of medicine, of limited use in saving or extending lives but incredibly lucrative in insights for investigators in immunology and other fields."

The Kornberg-Goulian achievement in life sciences research at Stanford, assembling an "artificial" gene from inert chemicals which succeeded in reproducing itself was a milestone in 1967 medical progress.

IV

With the near-perpendicular ascent of population growth, the theories of Malthus are being re-studied with considerable interest. In 1967, the



"There hasn't been a case like this reported in over 2,000 years."

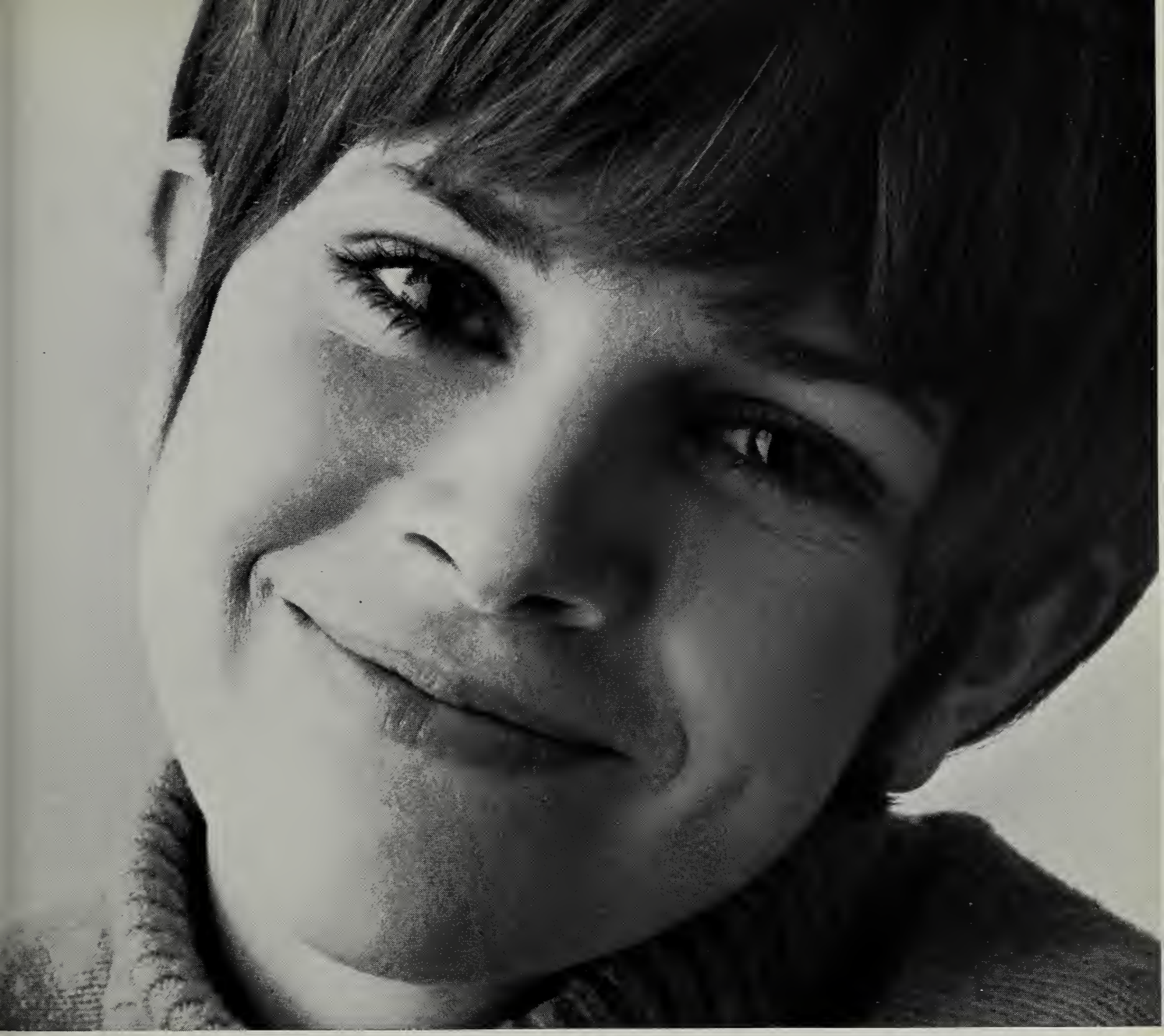


Photo professionally posed.

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This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin)

Wyeth®

President's Science Advisory Committee said that "the scale, severity, and duration of the world food problem are so great that a massive, long-range, innovative effort unprecedented in human history will be required to master it." The committee went on to say that the problem *demands* immediate programs of population control and that "to avoid a continued worsening of the population-food situation during the years beyond 1985 that may even reach *an economically or ecologically irreversible state of imbalance,*" every emphasis must be placed on family planning throughout the world.

This sort of grim warning makes welcome the appearance in 1967 of a second generation of contraceptive drugs. Significant changes are being made in state laws on therapeutic abortion, and AMA adopted a major revision of its policy in that respect.

New research on long-term contraceptive measures contemplates implanted, sustained-release preparations and injectable drugs. Work is continuing to devise a simple method for reliable prediction of ovulation some days in advance as a means of lifting the major barrier to use of the rhythm method, the only measure now fully acceptable to every person in the world.

Another depressing fact of science apparent in 1967 is that the battle against venereal disease is far from won. The Public Health Service reports that gonorrhea is more prevalent in the United States than at any time in the last 20 years, and the proportion of penicillin-resistant gonorrhea strains is growing. The reservoir of nonsymptomatic and untreated gonorrhea in females has been on the increase.

At year end, a near-epidemic onslaught of A2-like influenza was raging in the middle Atlantic states and moving west. There is public apathy toward the vaccine, too.

Drug abuse has zoomed with LSD and STP available on the street corner. Apart from the immediate and usually tragic effects of these hallucinogenic agents, the American Psychiatric Association reports that twice as many chromosomal abnormalities are found in the blood cultures of users than in those of nonusers. More alarming still, some investigators reported that the chromosome abnormalities discovered in some few LSD users resembled the Philadelphia 1-type chromosome previously observed only in patients with chronic myelogenous leukemia.

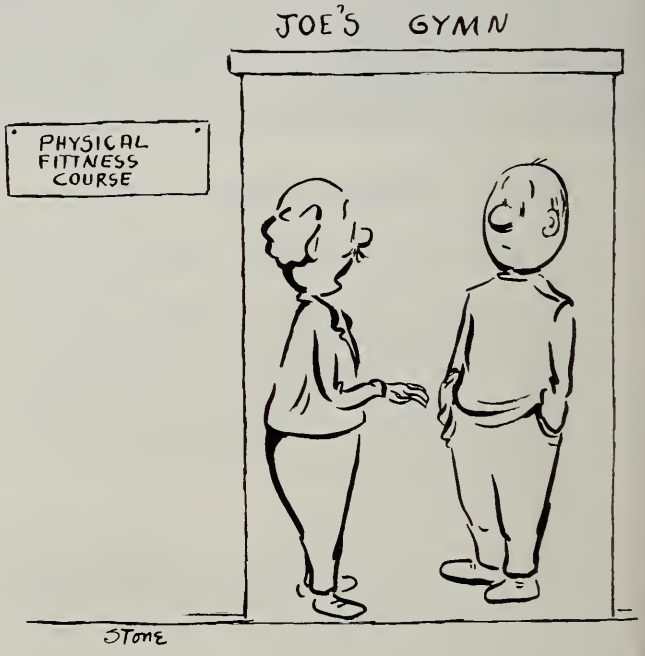
Indeed, 1967 was a year of problems and progress for medical science.

No year-end assessment is complete without the usual speculation on the future. Twenty top scientists of the Rand Corporation have come up with a bunch of dillies, but the forward thrust of science lends credibility to their prognostications.

As early as 1990, heredity defects will be controlled by genetic juggling, say the Rand think-tank spokesman. By 2010, biochemical stimulation of growth for new organs and even limbs should be possible. They say that the world's geometrically increasing population can be fed with cheaply produced synthetic protein in 20 years and that "food mining" from the oceans will be a major source of supply.

Here's one calculated to give a body the shivers: By 2020, there will be direct interaction between the computer and the human brain, and education may be achieved by direct "recording" on the brain. Look for chemotherapeutic control of the aging process and a 50-year increase in the present life span by 2025. In the same year, the Rand scientists foresee communication with extraterrestial beings, use of specially-bred animals for low-grade labor, and control of gravity.

In a parting shot, the Rand scientists say that two things will *never* come about, the science fiction buffs notwithstanding: These are full development of extrasensory perception and telepathy



"I'm a pediatrician, and yesterday, one of my patients beat me up."

for routine communication purposes and time travel.

And even on the day that the Lunar-Hilton is opened, the chances are that physicians will still be confronted with rising VD rates and public apathy toward vaccines.—R.B.K.

Ophthalmic Technicians: No Nonmedical Control!

Few groups are more active in the legislative field than optometrists. A review of the 1967 scoreboard shows that some sort of optometric legislation was considered in 20 state legislatures, most of which was beneficial to optometry. It is no secret that they will be active in the 1968 Regular Session of the Mississippi Legislature, and little speculation is involved in believing that their legislative effort will be aimed at improvement of their own legal climate.

Living up to their advance billing, the optometrists have introduced HB 39 in the Legislature which would require licensure of ophthalmic technicians—to include opticians—by the state board of optometry. Nominal author of the optometrists' bill is Rep. Alton Massey of Kosciusko. The bold and unprecedented move cuts directly into medical practice, because *it requires licensure of such technicians in the employ of a doctor of medicine.*

Enactment of such legislation would be untenable as regards physicians generally and ophthalmologists particularly. Since a physician is responsible for the care of his patient, he would gain no advantage in care quality assurances by such licensure. And there is no gainsaying that licensure and regulation of ophthalmic technicians by a nonmedical agency is neither necessary nor proper.

The state medical association opposes this legislative proposal. *Whether* such individual should be licensed and *how* this should be accomplished is clearly a *medical* matter where the employees of physicians are concerned. It is equally clear that an optometrist is not a doctor of medicine.

What is concomitantly important is that this is a matter of concern for all physicians, not just ophthalmologists. It is vitally necessary for a physician to retain full control over his personal assistants, first, for the assurance of care quality and second, for the full and responsible discharge of his lawful obligation for the care of his patient and his every professional act.

What the optometrists desire with respect to their employees is a matter for them to decide, and they must enjoy full freedom to do so. And by the same reasonable process of logic, medical matters must be decided by physicians. Nothing more, nothing less, and no control of a physician's employees by a nonmedical agency.—R.B.K.

Ionizing Radiation and Color Television

The color spectacular on the 23 inch screen in the family room may be a serious health hazard. Now, it's difficult to believe that the Green Bay Packers and Oakland Raiders can have a part in contributing to premature cataracts or genetic damage, but this is the verdict of the Public Health Service's National Center for Radiological Health. It isn't the programs but rather the ionizing radiation, and NCRH says it's there.

Last year, it was discovered that General Electric sold 110,000 color television sets with faulty tubes. While all vacuum tubes have some x-ray emission qualities, the GE sets were found to emit more than 100,000 times as much radiation than the safety level voluntarily set by the manufacturing industry. The "safe" x-radiation level so set is 0.5 milliroentgens per hour, measured at 5 cm from the source, operating at 120 volts.

In all fairness to GE and to Admiral and Packard-Bell, whose color TV receivers have also been listed in the excessive radiation bracket, it was admitted that tests of the so-called defective sets were made at 125 to 130 volts. This brought protests from the TV makers, who said that a single standard of testing ought to be followed. One manufacturer, Admiral, contended that its sets are tested at 130 volts and have been found to conform to industry-established limitations.

NCRH, who says that "the problem of x-ray emission from color TV has been understated," advocates a minimum safe distance of 6 to 10 feet between the receiving set and the viewer. Those indicting the color sets argue that children are usually much closer, much of the time on the floor immediately in front of the screen and consequently, in the area of most intensive radiation.

Still another problem is the use of Japanese-made components for American brand color TV sets. Forging ahead in high-quality, low-priced electronic products, Japan is a major supplier to the U. S. electronics industry. The Japanese scientists report that 15 per cent of their components exceed the industry-established minimums of radiation levels.

Even when faulty color TV sets are corrected

in moderate hypertension and poorly controlled mild hypertension

(when diuretics or sedatives are inadequate, for example)



When your patients expect a lot...

like relief from hypertensive symptoms
(headache, fatigue, nervousness, palpitation or insomnia, for example)

like an up-to-date, once-a-day dosage schedule
(a schedule not unlike timed-release medication, for example)

like a daily dose of medication for peanuts
(at 10¢ a tablet, for example)

like generally well-tolerated therapy
(as described in the package insert, for example)

...give them a little
(one tablet daily)

Regroton®

chlorthalidone 50 mg., reserpine 0.25 mg.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
For details, see complete Prescribing Information.

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

Geigy

by the manufacturer, says NCRH, the danger has not necessarily been removed. TV servicemen often increase the operating voltage to get a better, brighter picture and thereby increase radiation levels. When GE redesigned the radiation-emitting shunt tube, it was found that it was sometimes replaced with a defective tube by servicemen.

Last year, the American College of Radiology expressed the opinion that the radiation scare and withdrawal of some sets from the market might trigger federal controls over the TV manufacturing industry (*Newsletter,* Nov., 1967). Two bills to create and enforce radiation safety standards are now pending before the 2nd Session of the 90th Congress, H.R. 10780 and S. 2067. With canny savvy on the legislative climate, major American TV makers are actually supporting the measures. In the meanwhile, the industry's trade group, the Electronics Industries Association, says that voluntary standards have been stringent and are furnishing adequate safeguards.

As one wag put it recently: We knew that television was terrible, but we never thought of it as being dangerous.—R.B.K.

The Medi-Cal Misstatement: R.I.P.

It's about time to lay to rest once and for all the ludicrous and absurd charge that 1,200 physicians in California received $70,000 each for billings during a 16 months period for services under the state's Title XIX program. The California Medical Association, which, incidentally, runs the Medi-Cal Title XIX program, has asked the president of each state medical association to make the facts clear to their respective memberships.

"We wish to assure you and your members that this report is completely false," wrote CMA Executive Director Robert L. Thomas to President Ainsworth. "This reporter (who broke the sensational and misinformed story in the *San Francisco Examiner)* made the mistake of confusing 1,200 computer vendor units with 1,200 individual practitioners. His error has misled the public and unfairly blackened the name of the medical profession. Public retractions have been made, but unfortunately they never receive the front page headlines as does the initial charge."

Thomas goes on to explain that a computer vendor unit may be one or a number of physicians where the latter are organized in a partnership or clinic. And, to set the record straight in further detail, out of the top earning 1,200 vendor units under Medi-Cal, only 593 units were physicians, while 607 consisted of dentists, pharmacists, opticians, ambulance services, and suppliers of medical equipment.

The mean payment during the first year of the program to the 2,328 top earning California physicians was only $14,300, a far cry from the alleged $70,000 for all. Less than 4 per cent of the 80,000 care, service, and supply sources in California received as much as $20,000 during the first year and a half of the program.

Of the millions being paid out under Medi-Cal, about 19 per cent goes to physicians, 31 per cent to hospitals, 20 per cent to nursing homes, and about 30 per cent to all other service and supply sources.

Anybody with half a grain of common sense knows that the physician's share of the health care dollar has steadily declined during the past 10 years, while the extent and effectiveness of medical services in that period have increased by leaps and bounds. The California incident dramatizes the need for objectivity in reporting which, happily, is something which most news reporters understand and strive for. And now, may the "$70,000 paycheck" misstatement rest in peace. —R.B.K.

Solons Are Hit With Health Costs

Health and health-related programs cost real money, and members of the Legislature are quickly finding this out. The record $484 million budget for the 1968-70 biennium earmarks more than $76.6 million for such programs in 13 agencies of the state. This aggregate appropriation is up 16 per cent over the current biennium to the tune of $10.7 million against the overall budget increase of 13 per cent.

And this doesn't include a thin dime for a Title XIX program.

About $5 million in the health field is for state programs for which there is no federal matching money. This amounts to almost $2.8 million for the charity hospitals at Laurel, Meridian, Natchez, and Vicksburg, and carries an increase of $648,000 over 1966-68. Then there is about $1.8 million for the State Hospital Commission program which is down $347,000 because of Medicare. Finally, the Cerebral Palsy Hospital School is

slated for $395,000 with a modest increase of $18,500 over current spending.

Taken as the state's share for a Title XIX program and matched under the 83-to-17 ratio available to Mississippi, the appropriations for these three agencies would make available more than $29 million.

At best, the State Hospital Commission program meets about a third of actual hospital costs, and under the law, a physician is absolutely prohibited from charging, receiving, and accepting a fee for professional services. The state medical association strongly opposes this restriction and supported legislation for deletion of this portion of the law in 1966.

The four charity hospitals cannot serve the state equitably, as studies presented to the House of Delegates have shown. On any given day, about 60 per cent of their patient census represents residents of the counties in which the institutions are located. The Cerebral Palsy Hospital School has relatively few trainee-patients in comparison with admissions under the other two programs.

It has been made clear that state government is putting first priority on education with a revitalized highway program coming in as a close second. The solons are in general agreement that the knottiest problem is how to pay the bills for ongoing and new programs. This is the money dilemma which the 1968 Regular Session faces, and the cost of health care for the needy isn't the least of it.—R.B.K.

Coast Physician Leads Fight Against Pornography

Dr. Matthew F. Kuluz of Pascagoula, addressing the Moss Point Parent-Teachers Association, said that pornography can "pervert an entire generation of our children." The Coast pediatrician represented the Jackson County Citizens for Decent Literature, and his presentation included a film on "Perversion for Profit," dealing with obscenity and pornography.

Dr. Kuluz said that his purpose is to inform groups on what obscenity is, not to censor, not to boycott, and not to burn books. He discussed court decisions defining obscenity as material designed to appeal to "prurient interest, that is, to excite lustful thoughts."

He urged the P-TA group "to start with your own home" in promoting good reading and to work in public education against pornographic materials.



One by one
the family's downed
Because the
G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

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Fort Washington, Pa.





Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, Equanil® often may play an important role in medical and surgical aftercare.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported.

One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Wyeth® SERVICE TO MEDICINE

Equanil®

(meprobamate)

Wyeth

Professionally posed.

POSTGRADUATE CALENDAR

NEUROLOGIC DISORDERS OF CHILDHOOD

University Medical Center, Jackson
February 15, 1968, beginning at 8:30 a.m.

Sponsored by the University of Mississippi postgraduate education committee, the Department of Pediatrics and the Department of Medicine, Division of Neurology, with partial support from the National Institute of Neurological Diseases and Blindness and from the Children's Bureau.

Participants:

Arthur L. Drew, M.D., professor of neurology, Indiana University Medical Center

Robert Y. Moore, M.D., assistant professor of neurology, anatomy and pediatrics, University of Chicago School of Medicine

Blair Batson, M.D., professor of pediatrics and chairman of the department, University Medical Center

Margaret Batson, M.D., acting associate professor of pediatrics, assistant professor of psychiatry and microbiology, and chief, Division of Human Behavior, University Medical Center

Robert D. Currier, M.D., associate professor of medicine and chief, Division of Neurology, University Medical Center

Armin Haerer, M.D., assistant professor of medicine, University Medical Center

William Hicks, M.D., instructor in pediatrics, University Medical Center

Forrest Tutor, M.D., associate professor of neurosurgery, University Medical Center

Frank M. Wiygul, M.D., clinical assistant professor of pediatrics, University Medical Center

Thursday Morning

Degeneration Diseases of the Brain in Childhood
Dr. Moore

Certain Aspects of Seizure Disorders in Childhood
Dr. Wiygul

Infections of the Central Nervous System in Childhood
Dr. B. Batson

Clinical Symptoms Related to Disorders of Amino Acid Metabolism
Dr. Hicks

Degenerative Diseases of the Brain and Epilepsy in Childhood
Panel: Dr. B. Batson, Dr. Moore, Dr. Drew, Dr. Wiygul, Dr. Hicks

Thursday Afternoon

Reading Disabilities in Children
Dr. Drew

The Surgical Treatment of Congenital Disorders of the Nervous System in Children
Dr. Tutor

Causes of Mental Retardation
Dr. M. Batson

Summary Discussion
Dr. Haerer, Dr. Drew, Dr. M. Batson, Dr. Moore, Dr. Tutor

MANAGEMENT OF DIFFICULT FLUID AND ELECTROLYTE PROBLEMS

University Medical Center, Jackson
March 1, 1968, beginning at 8:30 a.m.

Sponsored by the University of Mississippi School of Medicine and the Mississippi Kidney Foundation.

Participants:

Elwin E. Fraley, M.D., director of urologic research, National Institutes of Health

Dale D. Lindholm, M.D., associate professor of medicine and director of Renal Unit, Tulane University School of Medicine

John Bower, M.D., assistant professor of medicine and director, artificial kidney unit, University of Mississippi School of Medicine

Ben B. Johnson, M.D., associate professor of medicine, University of Mississippi School of Medicine

Jose Montalvo, M.D., assistant professor of pediatrics, University of Mississippi School of Medicine

Lamar Weems, M.D., assistant professor of surgery, University of Mississippi School of Medicine

Friday Morning

Basic Fluid and Electrolyte Physiology
Dr. Lindholm

Problems of the Obstructed Kidney
Dr. Fraley

A Daily Fluid and Electrolyte Plan
Dr. Bower

Common Errors in Fluid and Electrolyte Management
Dr. Johnson

a tranquilizer with particular usefulness in functional disorders

Tybatran™

(pronounced TYE-buh-tran)

brand of tybamate

Extensive clinical experience, including eleven double-blind studies,[1-11] indicates that Tybatran is an effective agent for the relief of anxiety and tension. It appears to lend itself particularly well to the management of the anxious patient who "somatizes"—whose anxiety and tension find expression in complaints such as headaches,[4,8,10,11] fatigue,[4] insomnia,[2,4,8,9,12] anorexia,[3,8,9] and pruritus.[7]

Two salient features seem to set Tybatran somewhat apart from certain other commonly used tranquilizers.

1. Tybatran often proves more effective than meprobamate and chlordiazepoxide. In one study,[4] severe anxiety responded more effectively to tybamate than to meprobamate; in another,[8] symptom-response superiority of tybamate over chlordiazepoxide was marked at statistically significant levels of confidence.

2. Tybatran appears to be less sedating than other widely used tranquilizers. Side reactions are relatively infrequent; when they do occur, they may take the form of drowsiness, although insomnia, ataxia and other adverse effects have been reported. Nevertheless, Tybatran impresses many clinicians by its comparative lack of undesirable sedative action.[3,6,12,13] (If drowsiness or vertigo is present, activities requiring optimal alertness should be avoided.)

For patients in whom anxiety is manifested in any of a multiplicity of physical complaints, Tybatran deserves a clinical trial. These are the challenging patients, those with recurrent, persistent, ever-changing symptoms for which there is no clinical or laboratory evidence of organic disease.

Usual adult dose: one or two 250 mg. capsules 3 or 4 times daily. Adjust to suit individual requirements.

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Prescribing Information

Dosage and administration. The suggested adult dose of Tybatran (tybamate) is one or two 250 mg. capsules three or four times daily. Dosage should be adjusted to suit individual requirements. While clinical experience with Tybatran (tybamate) in children has been very limited to date, the recommended daily dosage for children 6 to 12 years old is 20 to 35 mg./kg. body weight, in three or four equally divided doses. Dosage should be adjusted to suit individual requirements. Until further clinical experience is obtained, administration of Tybatran (tybamate) to children under 6 years of age is not recommended. Daily doses larger than 3000 mg. are not recommended, although in a few instances doses in excess of this figure have been administered. Tybatran (tybamate) is also available in 350 mg. capsules, for convenience in dosage adjustment, e.g., one capsule three times daily and two at bedtime.

Contraindications. Tybatran (tybamate) should not be administered to patients known to be hypersensitive to the drug. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings. Simultaneous administration to psychotic patients of tybamate with phenothiazines and other central nervous system depressants has in a few instances been associated with the occurrence of grand mal or petit mal seizures. Seizures have been reported with administration of phenothiazines alone, but not with administration of tybamate alone; nevertheless, tybamate should be used cautiously in individuals who are receiving other central nervous system depressants or have a history of convulsive seizures. Also, it should be borne in mind that simultaneous administration of tybamate with alcohol or with other psychotropic agents, particularly phenothiazines or monoamine oxidase inhibitors, which are known to potentiate the action of other drugs, may result in additive actions.

Precautions. There has been no evidence to date of the development of habituation or addiction. Investigators have not observed excessive self-medication or any withdrawal symptoms with use of Tybatran (tybamate), but the latter should be kept in mind with cessation of the drug after prolonged use. Because of the occurrence of

Prescribing information continued on next page.

(pronounced TYE-buh-tran)

Tybatran™
brand of tybamate

a tranquilizer with particular usefulness in functional disorders

Prescribing information continued from preceding page.

withdrawal symptoms or exacerbation of presenting symptoms upon rapid withdrawal of other agents of this type, abrupt withdrawal of Tybatran (tybamate) should be avoided. Tybamate, like other psychotherapeutic agents, should be used with caution in addiction-prone individuals. Should symptoms of hypersensitivity occur, administration should be discontinued at once and appropriate symptomatic treatment initiated. Operation of motor vehicles or machinery or other activities requiring optimal mental alertness should be avoided if drowsiness or vertigo is present. As with any new drug, Tybatran (tybamate), should be used with caution in patients with a history of drug allergies, blood dyscrasias, and hepatic or renal disease; and prolonged and/or high doses of tybamate should be accompanied by periodic measurements of hepatic, hematopoietic, and renal function.

Adverse reactions. While these have only rarely required discontinuation of the drug, the most frequently encountered reactions have included drowsiness, dizziness, nausea, insomnia, euphoria. The drug was discontinued in one child because of a possible drug-induced urticaria, and skin rash and pruritus have been encountered in a few other patients. In a few patients, effects suggesting excessive stimulation such as hyperactivity, fidgetiness, flushing, and tachycardia have been encountered. Other reported side effects recorded only a few times to date have included ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients to whom tybamate (up to 6000 mg. daily), phenothiazines, and other psychotropic agents were administered simultaneously. Convulsive seizures have not been reported with the use of tybamate alone.

Until clinical experience has accumulated with this drug, inasmuch as tybamate is related to meprobamate, the physician should be cautious about the possibility of rare, serious adverse reactions such as may be encountered with the latter drug. Should excessive doses of tybamate be ingested, it is recommended that any drug remaining in the stomach be removed and symptomatic therapy, including central stimulants, be used as necessary.

Supply. Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

Bibliography.

1. Brick, H.: Doub, W. H., Jr., and Perdue, W. C.: Effects of tybamate on depressive and anxiety states in penitentiary inmates: a preliminary report. Int. J. Neuropsychiat. **2**:637 (Nov.-Dec.) 1966. **2.** Callis, S. B.: A new drug available for treatment of neurosis: double-blind study of tybamate. Int. J. Neuropsychiat. **2**:645 (Nov.-Dec.) 1966. **3.** Chesrow, E. J.; Kaplitz, S. E.; Sabatini, R.; Vetra, H., and Marquardt, G. H.: A new psychotherapeutic agent effective in the management of geriatric anxiety, depression and behavioral reactions. J. Amer. Geriat. Soc. **13**:449 (May) 1967. **4.** Chieffi, M.: A two-part, double-blind study of the anti-neurotic action of tybamate. Dis. Nerv. Syst. **26**:369 (June) 1965. **5.** Raab, E.; Rickels, K., and Moore, E.: A double-blind evaluation of tybamate in anxious neurotic medical clinic patients. Amer. J. Psychiat. **120**:1005 (Apr.) 1964. **6.** Seeherman, R.: Evaluation of tybamate in the clinical management of anxiety. Delaware Med. J. **36**:213 (Oct.) 1964. **7.** Shapiro, I.: Controlled study of the effects of tybamate on the neurotic component in dermatoses. Curr. Ther. Res. 8:99 (Mar.) 1966. **8.** Splitter, S. R.: A new psychotropic drug; evaluation of tybamate in the treatment of anxiety and tension states. Psychosomatics **5**:292 (Sept.-Oct.) 1964. **9.** Stern, F. H.: A new drug (tybamate) effective in the management of chronic brain syndrome. J. Amer. Geriat. Soc. **12**:1066 (Nov.) 1964. **10.** Vazuka, F. A., and McLaughlin, B. E.: Chemotherapy of symptoms of chronic anxiety states and other neurotic disorders. Psychosomatics **6**:73 (Mar.-Apr.) 1965. **11.** Button, J. T., and Cole, W. V.: Treatment of emotional disturbances in clinic patients. J. Amer. Osteopath. Ass. **64**:812 (Apr.) 1965. **12.** Slaughter, I.: Tybamate as an antineurosis drug in the treatment of emotional disorders. J. New Drugs **5**:177 (May-June) 1965. **13.** Dunlop, E.: Tybamate—A new tranquilizer: preliminary report. Mind **2**:115 (Apr.) 1964.

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DISTURBANCES OF SODIUM BALANCE AND WATER BALANCE
Dr. Lindholm

Friday Afternoon

MEDICAL AND SURGICAL ELECTROLYTE PROBLEMS
FLUID PROBLEMS IN ENDOTOXIN SHOCK
Dr. Weems
CASE PRESENTATION AND PANEL
Dr. Lindholm, Dr. Fraley, Dr. Johnson, Dr. Bower, Dr. Weems, Dr. Montalvo

SYMPOSIUM ON MEDICINE AND RELIGION

CARE OF THE TERMINALLY ILL

University Medical Center, Jackson
March 14-15, 1968

Sponsored by the University of Mississippi School of Medicine; the Department of Medicine and Religion, American Medical Association; the Committee on Medicine and Religion, Mississippi State Medical Association in cooperation with the Mississippi Academy of General Practice.

Participants

Rev. Paul B. McCleave, LL.D., director, A.M.A. Department of Medicine and Religion, Chicago, Ill.

Paul B. Brand, M.D., chief, Rehabilitation Services, U.S.P.H.S. Hospital, Carville, La.

Rev. Van Arnold, pastor, Evergreen Presbyterian Church, Memphis, Tenn.

Thursday Evening

Dinner, University Medical Center, 7 p.m.
PATIENT AND PARISHIONER—ONE PERSON
Rev. McCleave

Friday Morning

TERMINAL ILLNESS, WHERE PHYSICIANS AND CLERGYMEN MEET
The Role of the Physician, Dr. Brand
The Role of the Clergyman, Dr. Arnold
CONCURRENT GROUP DISCUSSIONS

Friday Afternoon

THE PARADOX IN MODERN MEDICINE
Rev. McCleave
SUMMER SESSION—PANEL
Rev. McCleave, Dr. Brand, Dr. Arnold and group discussion leaders

CIRCUIT COURSES

SOUTHWESTERN CIRCUIT

NATCHEZ—February 20, Jefferson Davis Memorial Hospital, 7 p.m.

Session 2—Diagnosis and Management of Anemia

In Adults, Dr. Guy Gillespie

In Children, Dr. Robert Carter

EASTERN CIRCUIT

Columbus—February 27, Aubrey and Ellon's Restaurant, 6:30 p.m.

Session 2—Current Approach to Tetanus Prophylaxis and Treatment, Dr. Raymond Martin

Evaluation and Management of Auditory Problems in Children, Dr. Godfred Arnold

EAST CENTRAL CIRCUIT

Meridian—March 5, Northwood Country Club, 6:30 p.m.

Session 1—Doctor-Patient Relationships, Dr. Joseph Roberts and Dr. Bob Baringer

FUTURE CALENDAR

February 15
NEUROLOGIC DISORDERS OF CHILDHOOD

February 20
CIRCUIT COURSE, NATCHEZ

February 27
CIRCUIT COURSE, COLUMBUS

March 1
SYMPOSIUM ON RENAL DISEASE

March 5
CIRCUIT COURSE, MERIDIAN

March 14-15
CARE OF THE TERMINALLY ILL

March 27-29
CARDIOVASCULAR SEMINAR

April 1-2
AMERICAN BOARD OF SURGERY

April 2
CIRCUIT COURSE, MERIDIAN

April 11
DIABETES SEMINAR

April 16
CIRCUIT COURSE, NATCHEZ

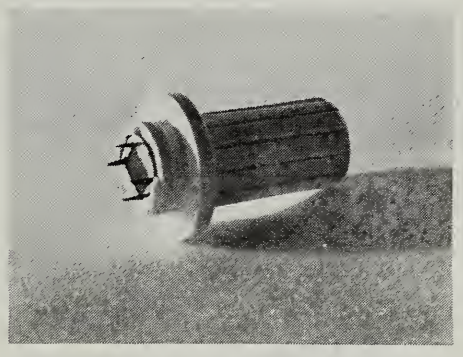
April 18
THORACIC SOCIETY

April 23
CIRCUIT COURSE, COLUMBUS

May 7
CIRCUIT COURSE, MERIDIAN

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.

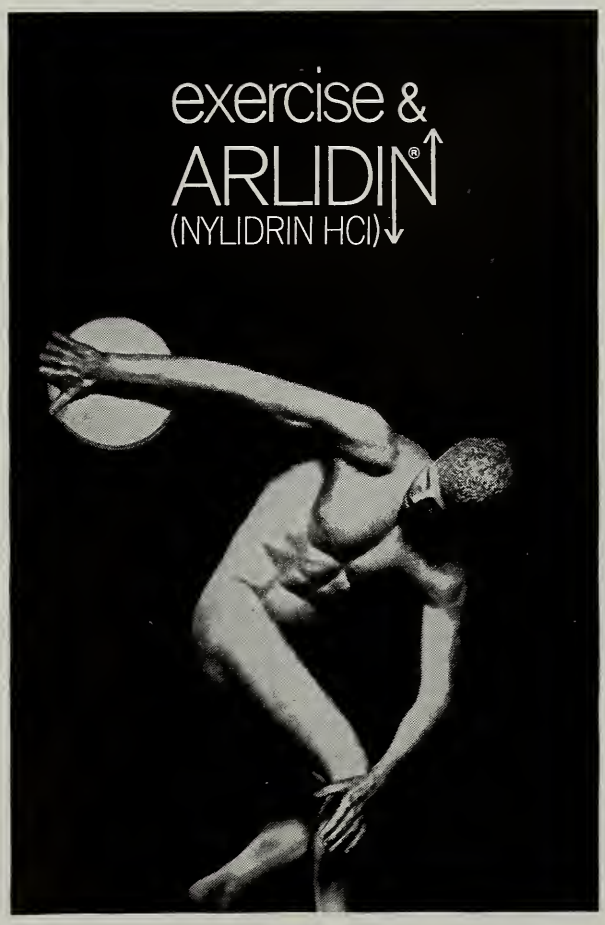


TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

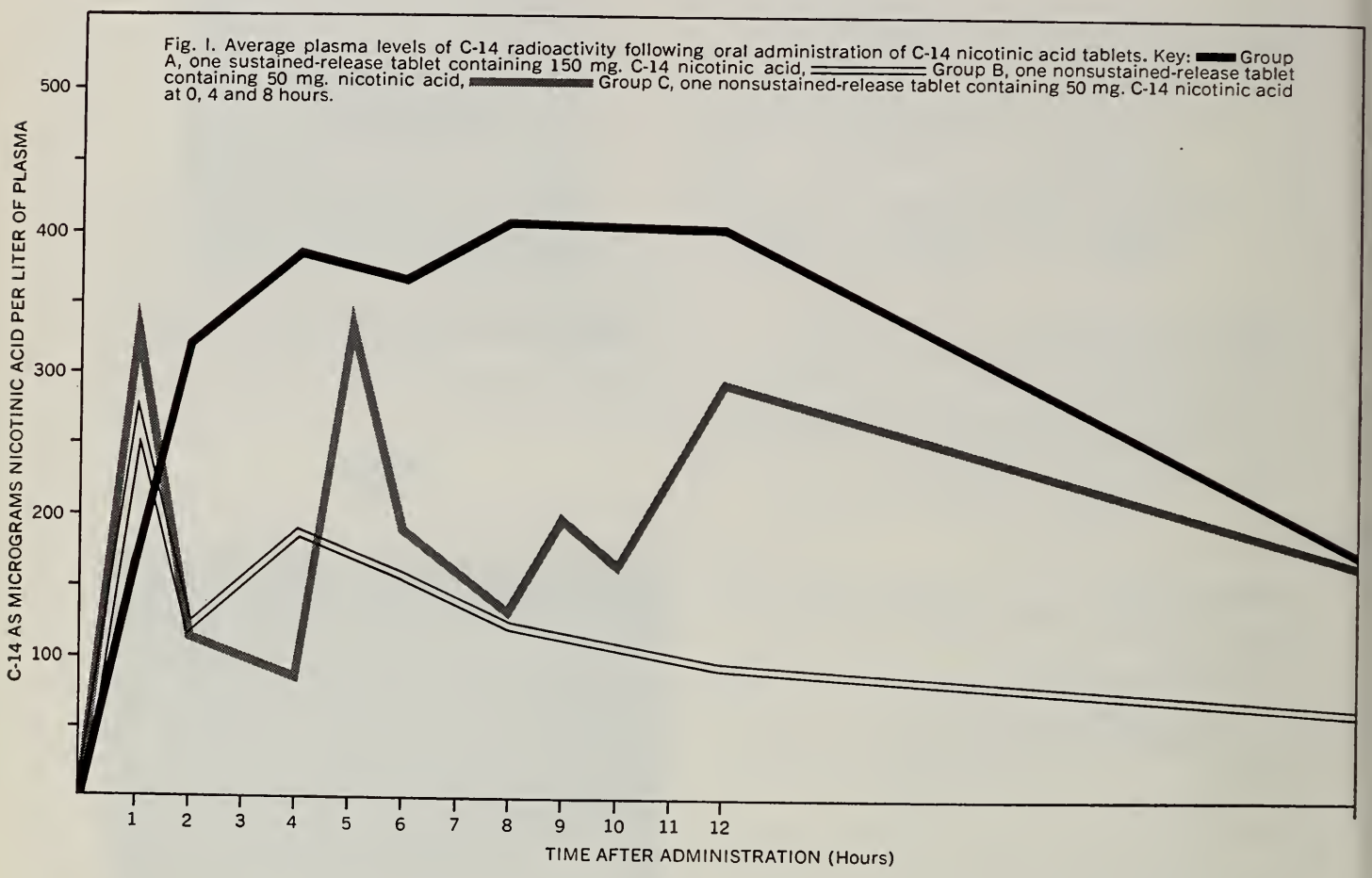
Lederle

330—8/6135



Sustained circulatory, respirator
and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

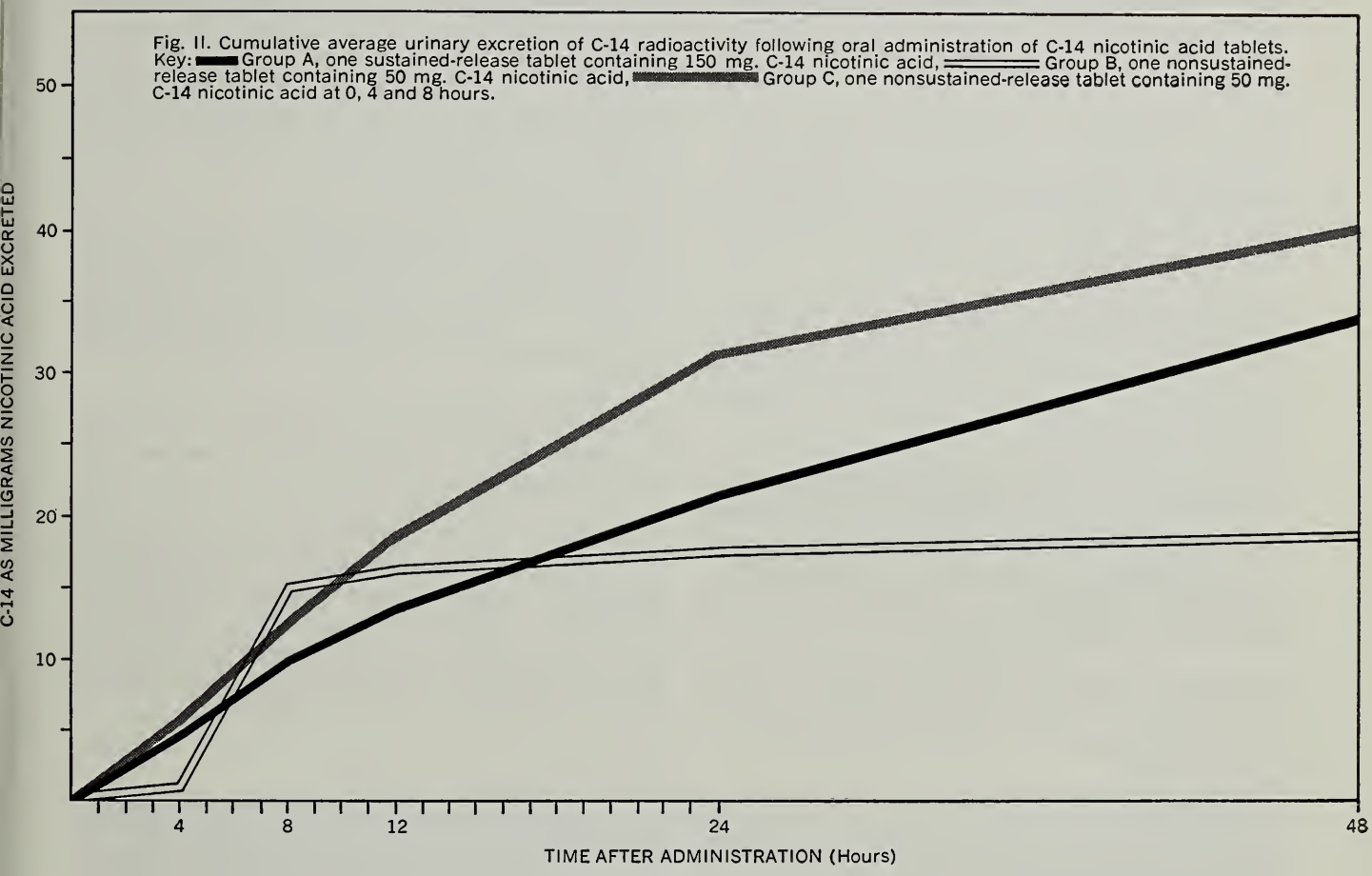
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

PERSONALS

JOHN G. ALEXANDER of Union has been appointed to the advisory committee to the Choctaw Area Council of the Boy Scouts of America for 1968. The Choctaw Council is a leading BSA area group with a 1967 membership increase, a record of 40 formal training courses, and the advancement in ranks of 730 boys during the year, including 28 to Eagle rank.

W. H. ANDERSON and WILLIAM H. PRESTON, JR., of Booneville were hosts to Dr. Alton Ochsner of New Orleans who recently addressed the Booneville Rotary Club.

THOMAS H. BLAKE of Jackson was honored by the National Foundation for 20 years continuous service on the March of Dimes Medical Advisory Committee. Dr. Blake is a pioneer orthopaedic surgeon in Mississippi.

EUGENE V. BRAMLETT of Oxford closed his private practice to assume duties as health officer for Panola and Quitman counties. He will have his headquarters at Batesville. Dr. Bramlett has practiced at Oxford since 1935 and is a third generation Mississippi physician.

GEORGE W. BYRNE of Pass Christian is serving as commodore of the Pass Christian Yacht Club and recently presided over the Fifth Annual Commodore's Ball.

JAMES R. CAVETT, JR., of Jackson was voted "Boss of the Year" by the Jackson Chapter of the American Association of Medical Assistants. Currently serving as president of the Central Medical Society, the Jackson internist was one of the professional advisers in the organization of the group. NANCY VARNADO of Jackson, executive secretary of the society, was honored as "Medical Assistant of the Year." She has served as president of the state group and has assisted in the organization of six AAMA chapters in Mississippi.

R. T. DABBS of Aberdeen has been re-elected chief of staff of the Aberdeen-Monroe County Hospital for 1968. Other officers of the staff are JOHN N. TURNAGE, vice chief, and ROBERT E. WOODRUFF, secretary.

DANIEL H. DRAUGHN of Jackson has been elected a Fellow of the American Academy of Pediatrics. He is affiliated with the Children's Clinic and serves as clinical instructor of pediatrics at the University Medical Center.

JAMES H. HENDRIX, JR., of Jackson recently served as a faculty member in a special symposium on maxillofacial trauma at the Walter Reed Army Medical Center at Washington. Thirty plastic surgeons participated in the symposium as part of a training program for more than 400 military and civilian surgeons. The symposium was jointly sponsored by the American Society of Plastic and Reconstructive Surgery, the American Association of Plastic Surgeons, and the Walter Reed Army Medical Center. Dr. Hendrix is chairman-elect of the Section on Plastic and Reconstructive Surgery of the Southern Medical Association.

FRED D. HILL of Hattiesburg has earned the rank of Life Master of the American Contract Bridge League. He was a founder of the Hattiesburg Duplicate Contract Bridge Club and has assisted in the organization of clubs in Columbia and Laurel.

WENDELL B. HOLMES of McComb won a new Ford Mustang in a Christmas event sponsored by the McComb Evening Lions Club.

I. C. KNOX, SR., of Vicksburg was honored for 50 years continuous membership in the Vicksburg Rotary Club. A special occasion, "Ike Knox Day," was recently conducted during which a testimonial scrapbook was presented to Dr. Knox. He is an Emeritus member of the state medical association and at Ole Miss in 1908, he was a four-letter athlete, winning All-Southern and All-American honors in football.

WESLEY L. MCFARLAND of Bay St. Louis has been elected chief of staff of the Hancock General Hospital for 1968. Serving with him are M. L. DODSON of Waveland, vice chief of staff, and CHARLES J. COX of Bay St. Louis, secretary. During 1967, M. J. WOLFE, SR., of Bay St. Louis headed the hospital staff.

GEORGE W. OWEN of Jackson has been elected regional vice president of the American Association for Clinical Immunology and Allergy. The organization is currently working to attract more young physicians into the medical subspecialty of allergy.

H. C. RICKS, SR., of Jackson has been honored by the Selective Service System for 25 years service on the state appeals board of the Southern Judicial District. Dr. Ricks is a past president of the state medical association and a former member of the Board of Trustees.

Parchman Plasmapheresis Program Is Successful, Assists Rehabilitation Effort

The plasmapheresis program at Parchman State Penitentiary has won the enthusiastic approval of the state medical association's Committee on Blood and Blood Banking. Dr. Kenneth M. Heard of Jackson, chairman of the group, said that a committee meeting and on-site inspection of the medical facility at Parchman was conducted and that the project measured up fully to the expectations hoped for and goals set.

The program, authorized by Senate Bill 1643 which was enacted during the 1966 Regular Session of the Legislature, is conducted under contract with Cutter Laboratories of Berkeley, Calif. It is licensed by the National Institutes of Health and meets federal criteria with reference to processing of blood and blood products.

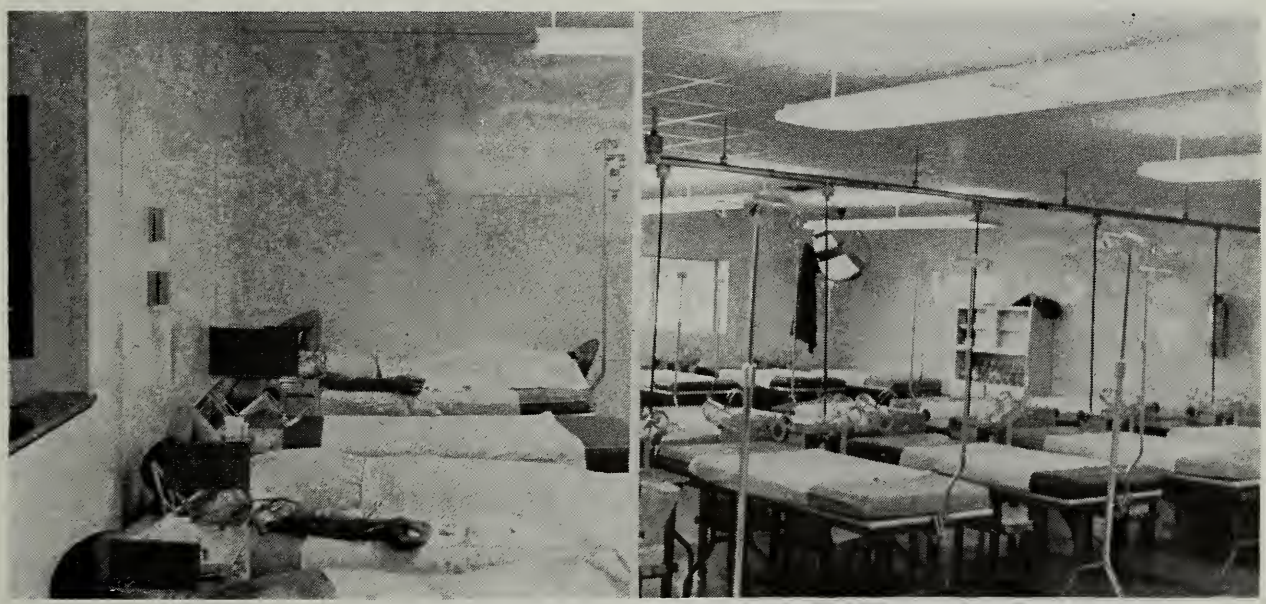
Participation in the plasmapheresis program by Parchman inmates is voluntary, and the present rate shows that as many as 20 per cent of the 3,000 prison population are offering plasma weekly. In the process, whole blood is drawn, and the red cells are returned to the donor after separation of the plasma.

When initially proposed in 1966 by Sen. Corbet L. Patridge of Schlater, the association, through the Committee on Blood and Blood Banking, gave the measure its approval contingent upon conduct of the program under full medical supervision, voluntary participation, federal licensure, and in a suitable and safe clinical environment. Although warmly debated in the House and Senate, the measure was passed.

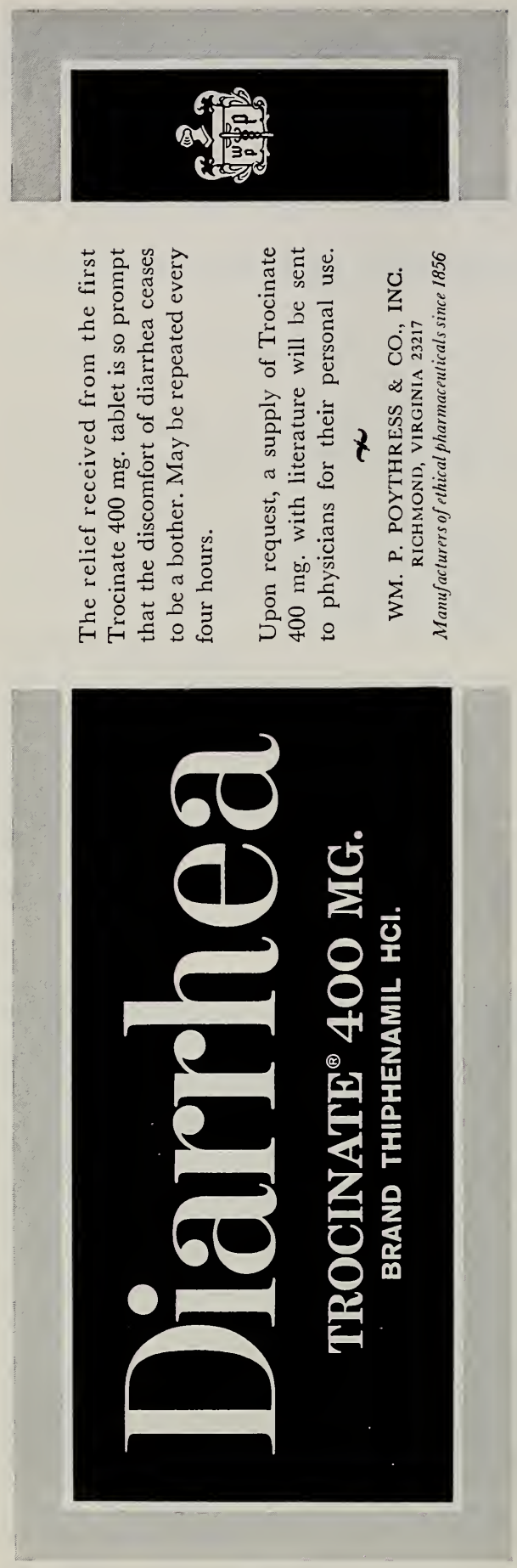
Dr. Heard said that "Cutter Laboratories has constructed a splendid facility for the program and has arranged for physician supervision. The equipment is of the best quality, and adequate controls have been instituted."

Dr. Richard H. Flowers heads the program. He has made Greenwood his permanent residence, commuting to the state institution on days when blood is drawn and processed.

The committee said that Cutter pays $6.50 per



Patients give plasma in modern clinical facility at plasmapheresis center. Identity is obliterated in keeping with public policy on anonymity of inmates. Right, view of main room where plasma is drawn.



donor session for plasma. Of this total, the volunteering inmate receives $4 in cash for personal use. The social and occupational rehabilitation fund of the institution receives $1.50, and $1 is conserved to the inmate's credit to be paid upon his release.

In addition, a staff of 15 inmates work full time in the processing facility. The rehabilitation fund benefits substantially from this service, bringing a total of more than $60,000 per year into the total rehabilitation effort. Through the fund, counseling and new skills are made available to all Parchman inmates. This work was the subject of a recent feature story in *Rehabilitation Review,* published by the Vocational Rehabilitation Division, but mention of the plasmapheresis program funding was not made.

Speaking for the committee, Drs. Catherine G. Goetz of Jackson, Charles B. Mitchell, Jr., of Meridian, Richard H. Fenstermacher of Vicksburg, and Thomas F. Puckett of Hattiesburg, Dr. Heard said that the group "is favorably impressed with the permanent facility which has been constructed, with the personnel, the direction of the program, and with the overall beneficial effect on the institution.

"As many as 600 donors per week are being processed through the program," Dr. Heard continued. He said that "an inmate who has given blood for plasma is a 'walking advertisement' for the program."

In the carefully controlled facility, volunteers receive screening examinations and blood tests to determine the feasibility of drawing their blood. Those accepted are required to bathe in showers in the facility and dress in disposable paper garments before the blood is drawn. After separation of the plasma, the red cells are returned to the donor.

The committee said that donors who have given as much as 700 to 800 cc of plasmas weekly for periods of three years in other programs have experienced no adverse or untoward effects. These donors are followed carefully with such procedures as protein electrophoresis.

There are two basic procedures from which plasma may be derived. The most familiar is the drawing of whole blood, but it has the disadvantage of having the cellular components discarded or wasted. Plasmapheresis is much more efficient, and is employed as the second method through which the plasma is separated and the donor's cellular components may be reinfused at the time of donation. Since the reinfusion of the red cells is accomplished in a volume of sodium chloride solution equivalent to the amount of plasma removed, the donor is minimally affected,

and his capacity for work and exercise is unhampered by the procedure.

The committee, consisting of five pathologists, has emphasized that plasmapheresis donors can give about four times the volume over the whole blood donors.

Fractional derivatives include fibrinogen and hyperimmune tetanus globulin, as well as other protein substances.



Two of four refrigerated centrifuges are examples of modern equipment in Parchman plasmapheresis center.

Federal licensure of the program through the Division of Biologics Standards of the National Institutes of Health requires that donors be protected for health and safety. Each volunteer must meet normal age, weight, blood pressure, temperature, and hemoglobin criteria. Since the unique proteins in human blood plasma are partially regenerated by the liver, hepatic function is also important, Dr. Heard said.

At the 99th Annual Session in 1967, the House of Delegates approved the program and charged the Committee on Blood and Blood Banking with monitoring the undertaking. The House stated that "we commend the concept and operation of this program and urge the committee to continue to monitor it closely." Dr. Heard said that this was the chief purpose of the committee's on-site meeting and inspection.

He reported "full cooperation from Cutter representatives and Parchman officials."

Professional Liability Rates Are Revised

Sharp premium rate revisions are being made effective for professional liability insurance coverage with increases ordered for 20 states. These range from a low of 10 per cent additional premium in four states to a high of 50 per cent in Arizona.

Mississippi professional liability rates are being rearranged, according to insurance industry spokesmen, but in the aggregate, are not being increased. The action will result in slight decreases in premiums for some state physicians and slight increases for others.

Member insurance companies of the National Bureau of Casualty Underwriters began filing application with state insurance commissions soon after the pre-Christmas announcement of the action, and nonmember companies followed closely.

Since the inception of the Mississippi State Medical Association's program with the St. Paul Companies, professional liability insurance rates in the state have decreased 50 per cent. The coverage is currently written in four classifications with rates graduated upwards for certain specialties and types of medical practice.

Class 1, with a basic premium rate of $28 per year for $5,000/$15,000 coverage, includes those who do no surgery or obstetrical procedures. Class 2, set now at $35 for the basic 5/15, covers physicians who do minor surgery and obstetrical procedures. Class 3, pegged at $68, covers those doing major surgery and also includes anesthesiologists, cardiologists, ophthalmologists, and proctologists.

Class 4 covers the remaining specialties and major surgery with an annual premium of $99 for the basic coverage.

The revisions will reshuffle Classes 2 and 3 and create a new Class 5, the spokesmen said.

Under the rearrangement, the basic rate for Class 1 will decrease to $25, and that for Class 2 will be set at $44. Class 3 will be defined as covering those performing major surgery and proctologists and ophthalmologists, with a rate of $75.

The Class 4 group will carry a rate of $100 and cover general surgeons, cardiac surgeons, otolaryngologists not performing plastic surgery, thoracic surgeons, urologists, and vascular surgeons.

The new Class 5, with a rate of $125, applies to anesthesiologists, obstetricians-gynecologists, plastic surgeons, neurological surgeons, orthopaedic surgeons, and otolaryngologists performing plastic procedures. Hardest hit are anesthesiologists, moving from the old Class 3 at $68 to the new Class 5 at $125.

Insurance industry spokesmen said that the rates reflected experience under the program with reference to actual costs. As of Dec. 31, 1967, the St. Paul program covered 477 members of the state medical association.



Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

New–Two Pediatric Forms of Erythromycin and Triple Sulfas





ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

701358

ABBOTT

MSMA Begins Study on PG Medical Education

A comprehensive study of postgraduate medical education in Mississippi has been initiated by the state medical association's Council on Medical Education. The ambitious project was approved by the Board of Trustees at its mid-winter meeting and will be conducted in partnership with the Regional Medical Program of the University Medical Center.

Dr. William O. Barnett of Jackson, chairman of the council, said that his group had become convinced that "the case for innovation, reorganization, direction, and increased effectiveness of postgraduate medical education is so clearly and forcefully supported by the overwhelming weight of all valid evidence that major research and studies should be undertaken."

The council's goals in the study will include assessing and defining the dimensions of the problem as it exists among medical practitioners in the state, evaluating existing programs of postgraduate medical education as to adequacy and effectiveness, examining in depth the individual desires, concepts of personal need, and instructional methodology preferences of Mississippi physicians, and determining the majority opinion as to postgraduate medical education from every major specialty society in the state.

Dr. Barnett said that the project will include a membership-wide survey to determine physicians' individual opinions and expressions of preference and personal need. The survey was begun soon after Christmas, he said, with a pre-testing of questions in three counties. The fall survey is now underway.

Leaders of specialty societies will be personally interviewed, and use will be made of records of postgraduate activities during the past two years. Formal postgraduate attainment will be gleaned from association records and processed by IBM.

The council chairman said that four months were programmed for the study project and that it will be the goal of the group to have a formal report for the House of Delegates at the 100th Annual Session in May. Serving with Dr. Barnett on the council are Drs. Dennis E. Ward of Corinth and R. Mayo Flynt of Meridian.

In making the announcement of the study and its importance to every physician, Dr. Barnett appealed for the membership to complete and return survey forms promptly. He stressed that any postgraduate medical education program developed from the study will be only as satisfactory

as the guidance and advice which the council receives in the course of its inquiries.

Two Shield Plans Go Usual and Customary

Two more Blue Shield plans have joined the growing group in paying usual and customary fees and full benefits for stated services. This was the report of the National Association of Blue Shield Plans on Rhode Island and South Dakota Blue Shield.

The Rhode Island plan is now providing paid-in-full benefits for x-ray, whether in the hospital, the hospital outpatient department, or the physician's office. Benefits are also paid in full for ECG's and radiotherapy and isotopes in or out of the hospital.

The South Dakota plan is now paying physicians their usual and customary fees for inpatient medical services up to 365 days per spell of illness, for surgical services together with assistants at surgery, and for all x-ray services, whether diagnostic or therapeutic, in or out of the hospital.

Under the Rhode Island plan, physicians may file notice of alteration of usual and customary fees on an individual basis, but changes will be made in profiles only one time annually. The plans announced the new benefits structures Jan. 1, according to NABSP.

Newest Component Names 1968 Officers

The Prairie Medical Society has named Dr. John C. Longest of Starkville its 1968 president. Other society leaders for the new year are Dr. Thomas N. Braddock, Jr., of West Point, president-elect, and Dr. Leonard H. Brandon, Jr., of Starkville, secretary.

The society, newest component of the state medical association, was chartered Jan. 1, 1966, following authorization by the House of Delegates at the 97th Annual Session in 1965. Its professional jurisdiction includes Clay, Lowndes, Oktibbeha, and Noxubee counties, and in 1967, the society was one of eight in the state association having 100 per cent renewal of membership.

The annual meeting of the society was conducted at the student union of Mississippi State University.

Dr. Crawford Is First Doctor of the Day



William Mitchell, left, assistant to Gov. John Bell Williams, greets Dr. Everett Crawford as the first Doctor of the Day in the association's Emergency Medical Care Unit at the Capitol. Warm smiles give hint to warm greeting: Both are natives of Tylertown.

MSMA Membership Remains Stable in 1967

Membership in the Mississippi State Medical Association remained relatively stable during 1967, but the percentage of membership among licensed physicians actually increased to 78 from 76 per cent.

Most dramatic development in the past year was a decrease in the number of licentiates in the state which decreased to 1,753 in 1967 from 1,849 in 1966. Association spokesmen said that this does not represent a mass exodus of 96 physicians from Mississippi but rather reflects the fluid circumstances of growing training programs and licensure of residents as well as the sharp bite of the Doctor Draft last year.

The state medical association's rolls showed 1,373 members alive and in good standing on Dec. 31, 1967, as opposed to 1,398 at 1966 year end, a numerical decrease of 25 members. Half of the decrease was in members exempt from dues. The loss amounted to 1.8 per cent, but there was a 3 per cent increase in membership-to-licentiate ratio.

Eight component medical societies of the association renewed 100 per cent of their 1966 membership during 1967, and three societies showed gains. Of special interest, the statement



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Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

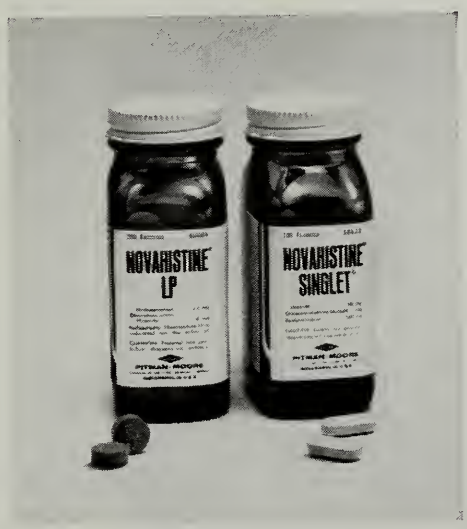
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

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continued, was growth in both the Northeast Mississippi and Prairie medical societies which, prior to 1966, were a single unit.

Societies securing 100 per cent of their renewable 1966 membership during 1967 were Amite-Wilkinson County, Claiborne County, Clarksdale and Six Counties, Delta, DeSoto, Northeast Mississippi, Pearl River, and Prairie medical societies.

The tallies do not include members in good standing for 1967 who died during the year. Until three years ago, such members were reported in final totals, but they are now excluded so as to match the reporting system utilized by the American Medical Association which subtracts deaths from reported totals.

Detailed analyses of the 1967 membership totals by dues-paid, exempt, and Emeritus categories have been furnished to secretaries of component medical societies.

Tallahatchie Honors Dr. Paul R. Googe

Citizens of Tallahatchie County honored Dr. Paul R. Googe of Charleston on the anniversary of his 30th year of continuous medical practice in the community. The honoree received plaques both from the Tallahatchie General Hospital and from the Charleston Clinic.

Highlight of the day honoring Dr. Googe was a meeting in the auditorium of the East Tallahatchie High School and the appearance of Rep. Jamie L. Whitten as featured speaker. Master of ceremonies was veteran state Rep. George Payne Cossar.



Dr. Paul R. Googe of Charleston, left, receives plaques from hospital administrator Thomas O. Logue during "Dr. Paul R. Googe Day" which honored his 30th year in practice in Tallahatchie County.

A reception at the Tallahatchie Country Club, also in Dr. Googe's honor, topped off the occasion. Press reports stated that hundreds of local citizens joined in participation and attendance.

Mississippi Action Shapes AMA Policy

A resolution sponsored in the AMA House of Delegates in June of 1967 by the Mississippi State Medical Association has influenced a new and major policy statement of American medicine. The resolution was initially adopted by the Delta Medical Society after presentation by its author, Dr. John M. Alford, Jr., of Greenwood.

As adopted by the House of Delegates at the 99th Annual Session last May, the resolution resolved "That our organization take steps to establish healing in the Principles of Medical Ethics as the central aim and aspiration of the AMA." The resolution was presented at national level by Dr. Howard A. Nelson of Greenwood, now senior delegate to AMA from Mississippi.

As developed by the AMA Board of Trustees to whom the resolution was referred, the policy contains broad initiatives in advancing health care for all Americans in an expanded statement of purposes and responsibilities of AMA. It was adopted by the House of Delegates at the recent Houston clinical convention.

The 11-point document greatly enlarges upon the previous statement of AMA purposes. It puts the skills and resources of the world's largest medical organization behind a continuing effort to stimulate progress in all aspects of health care in America.

The statement declares that it is the responsibility of the AMA, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people and to discharge that responsibility through the following means:

—By encouraging the advancement of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.

—By creating incentives to attract increasing numbers of capable people into medicine and the other health-care professions.

—By advancing and expanding the education

of physicians and other groups in the health-care field.

—By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.

—By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

—By developing techniques and practices that will moderate the costs of good medical and health care.

—By seeking out and fostering means of making all health care facilities—physicians' offices, hospitals, laboratories, clinics and others—as efficient and economical as good medical practice and attention to human values will permit.

—By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.

—By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

—By maintaining the highest level of ethics and professional standards among all members of the medical profession.

—By providing leadership and guidance to the medical profession of the world in meeting the health needs of changing populations.

ACP Slates Alabama Meet

The American College of Physicians (ACP) will sponsor a regional scientific meeting for specialists in internal medicine in Alabama, Feb. 23-24, in Point Clear. It will be sponsored jointly with the Alabama Society of Internal Medicine.

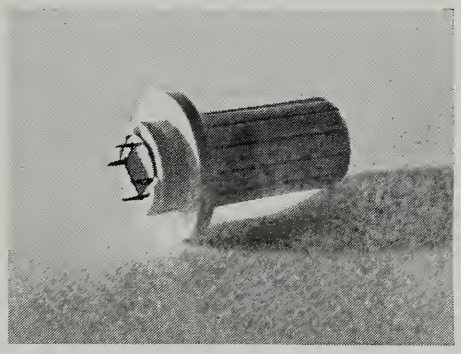
The meeting, which will be held in the Grand Hotel, is one of 37 scientific educational meetings sponsored by the ACP during the academic year.

Among special guests will be Dr. Carter Smith of Atlanta, ACP Regent and clinical professor of medicine at Emory University School of Medicine, and Dr. Edwin C. Evans, also of Atlanta, trustee of the American Society of Internal Medicine.

The meeting is being planned under the joint direction of Drs. Howard L. Holley of Birmingham, ACP Governor for Alabama and professor of medicine at the University of Alabama School of Medicine, and Dr. John F. Wade, Jr. of Montgomery, president of the Alabama Society of Internal Medicine and an instructor in medicine at the University of Alabama School of Medicine.

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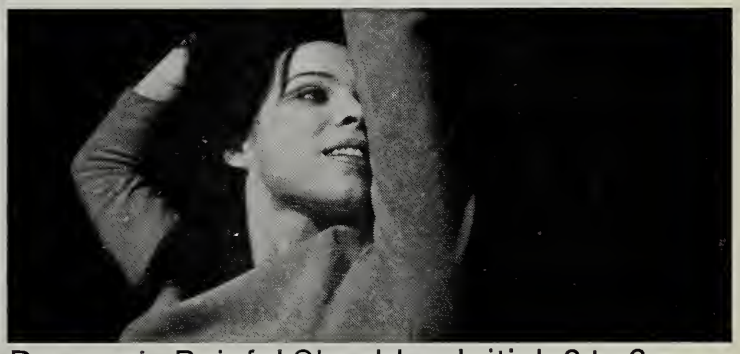
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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



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LETTERS

SIRS: This is in reply to a letter to the Editor by Dr. E. C. Stone of Oxford (J.M.S.M.A. VIII: 718-719 (Dec.) 1967) which contained a discussion of an article written by me in the JOURNAL (J.M.S.M.A. VIII:455-458 (Aug.) 1967) in regard to workmen's compensation.

Dr. Stone's letter is a reiteration of the opening sentence of that article. Along in the article, specific criticisms of forms were voiced, but the reasons for other parts of the forms were acknowledged.

The Committee on Occupational Health for MSMA has repeatedly offered its services to the Mississippi Workmen's Compensation Commission on a basis for consultation, but its services have not yet been sought.

The article had a two phase purpose: One, to stimulate physician recognition and acceptance of their responsibilities in regard to prompt filing of necessary forms; and second, to stimulate thoughts in regard to the forms in order that improvement might be gained.

Dr. Stone has responded in a meaningful manner. It is our hope that others may do likewise. that we may have as many suggestions as possible, and that our committee might be instructed in the direction in which it might pursue this matter.

GEORGE D. PURVIS, M.D., CHAIRMAN
COMMITTEE ON OCCUPATIONAL HEALTH
MISSISSIPPI STATE MEDICAL ASSOCIATION
421 S. STADIUM CIRCLE
JACKSON, MISS. 39216

SIRS: I have just finished reading my copy of the December issue of the JOURNAL. As always, I found many items of interest. I was particularly glad to see the item on the ACOG survey on the use of oral contraceptive pills, since we felt that this was an important effort in public education. Of interest also was the news about the University Medical Center, including the Dec. 14 postgraduate program on Modern Management of Common Obstetrical Problems.

I count myself very privileged to continue to receive the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, as it provides useful

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scientific information, serves many pleasant memories, and reminds me of many old friends.

MICHAEL NEWTON, M.D., F.A.C.O.G.
DIRECTOR, AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY
79 W. MONROE ST.
CHICAGO, ILL. 60603

DEATHS

HAYS, FRANK BUFORD, Columbus. M.D., University of Tennessee, Memphis, Tenn., 1943; interned Hillman Hospital, Birmingham, Ala.; residency John Gaston Hospital and Kennedy Veteran's Administration Hospital, Memphis, Tenn.; charter member of the Prairie Medical Society; died January 1, 1968, aged 47.

MCNAIR, STIRLING SHARP, Jackson. M.D., Jefferson Medical College, Philadelphia, Penn., 1929; interned Episcopal Hospital, Philadelphia, Penn.; past President and Secretary of the Central Medical Society. Diplomate, American Board of Ophthalmology; died January 5, 1968, aged 62.

MECKLIN, JAMES NAYLOR, Louise. M.D., University of Tennessee, Memphis, Tenn., 1900; interned State Charity Hospital, Vicksburg, Miss.; Emeritus member of MSMA and member of Fifty Year Club; died November 21, 1967, aged 91.

RICHARDS, WILLIAM EVANS, Artesia. M.D., Jefferson Medical College, Philadelphia, Penn., 1895; interned King County Hospital and Willard Parker Hospital, New York, New York; Emeritus member of MSMA and member of Fifty Year Club; died December 31, 1967, aged 96.

NEW MEMBERS

PARKER, JOHN MILLER, Rosedale. Born Biloxi, Miss., September 21, 1930; M.D. University of Mississippi School of Medicine, Jackson, Miss., 1957; interned Confederate Memorial Hospital, Shreveport, La., one year; elected November 1, 1967, by Clarksdale and Six Counties Medical Society.



MSD Mumps Vaccine Is Licensed

Federal licensure has been given to the live, attenuated mumps virus vaccine which is especially recommended for adolescent and male adults. The vaccine was developed over a five year period by Merck, Sharp and Dohme Laboratories.

It is not recommended for routine use in infants and young children pending development of more information as to the duration of immunity which it provides.

Commenting on the vaccine, Dr. William H. Stewart, U. S. Surgeon General, said that excellent protection against naturally occurring mumps has been observed for the first year after the single-infection live vaccine.

"But limited data on natural exposure during the second year indicate continuing protection, although additional observation will be required to determine the duration of immunity protection," Dr. Stewart added.

RMP Meeting Is Held at Jackson

Regional Medical Program coordinators from the mid-south met at Jackson in January to com-



Conferring over Regional Medical Programs are, from the left, Drs. Guy D. Campbell, Winston Shorey, Arkansas coordinator, Robert Q. Marston, and Joseph Norton, president of the Arkansas Medical Society.

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pare programs in major university centers. Site of the meeting was the University Medical Center under which the Mississippi Regional Medical Program is conducted.

Dr. Robert Q. Marston of Bethesda, Md., director of the programs nationally and associate director of the National Institutes of Health, was present to confer with state RMP directors. Dr. Marston was formerly dean and director of the University Medical Center.

The Mississippi program head is Dr. Guy D. Campbell of Jackson.

Dr. Cavett Heads Central Medical Society

Dr. James R. Cavett, Jr., of Jackson has been inaugurated president of the Central Medical Society, the largest component body of the state medical association. Serving with him in 1968 are Drs. Frank W. Bowen of Carthage, president-elect, and William O. Barnett of Jackson, secretary-treasurer.

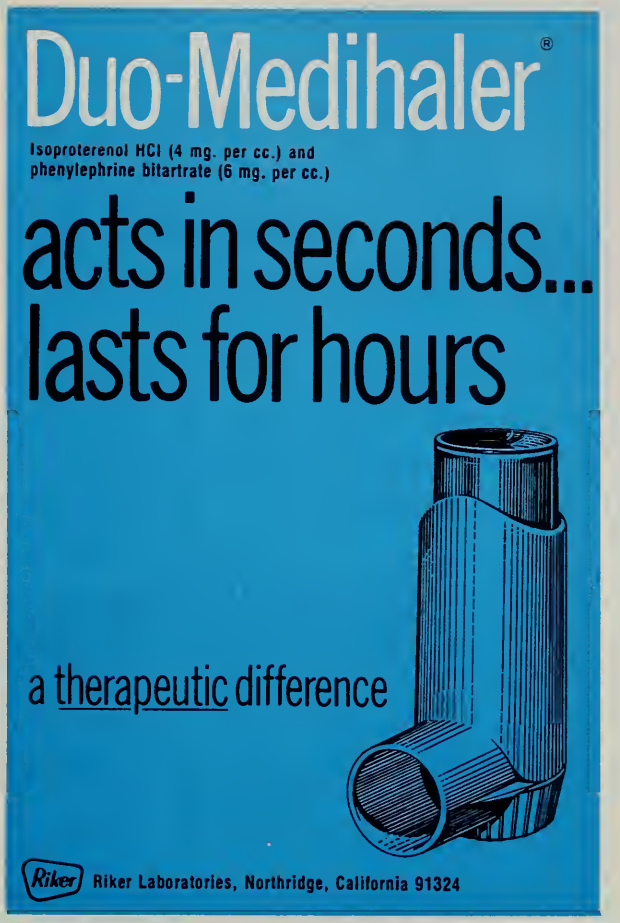
The eight county society covers Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, and Yazoo Counties. Mrs. Nancy Varnado of Jackson is executive secretary of the society.

South Central Names 1968 Officers

Members of the South Central Mississippi Medical Society, meeting at McComb, named Dr. Lamar Puryear, Jr., of Hazlehurst as president for 1968. He assumed office at the annual meeting of the society.

Dr. Julian T. Janes of McComb was re-elected secretary of the society. Vice presidents named are Drs. Thomas F. McDonnell of Hazlehurst, Copiah County; Jack W. Hollingsworth of Meadville, Franklin County; John W. Waller of Monticello, Lawrence County; M. H. Brown of Brookhaven, Lincoln County; John W. Boyd of McComb, Pike County; and James L. McLain of Tylertown, Walthall County.

Dr. Temple Ainsworth of Jackson, president of the state medical association, addressed the members of the society and Auxiliary at the annual meeting.



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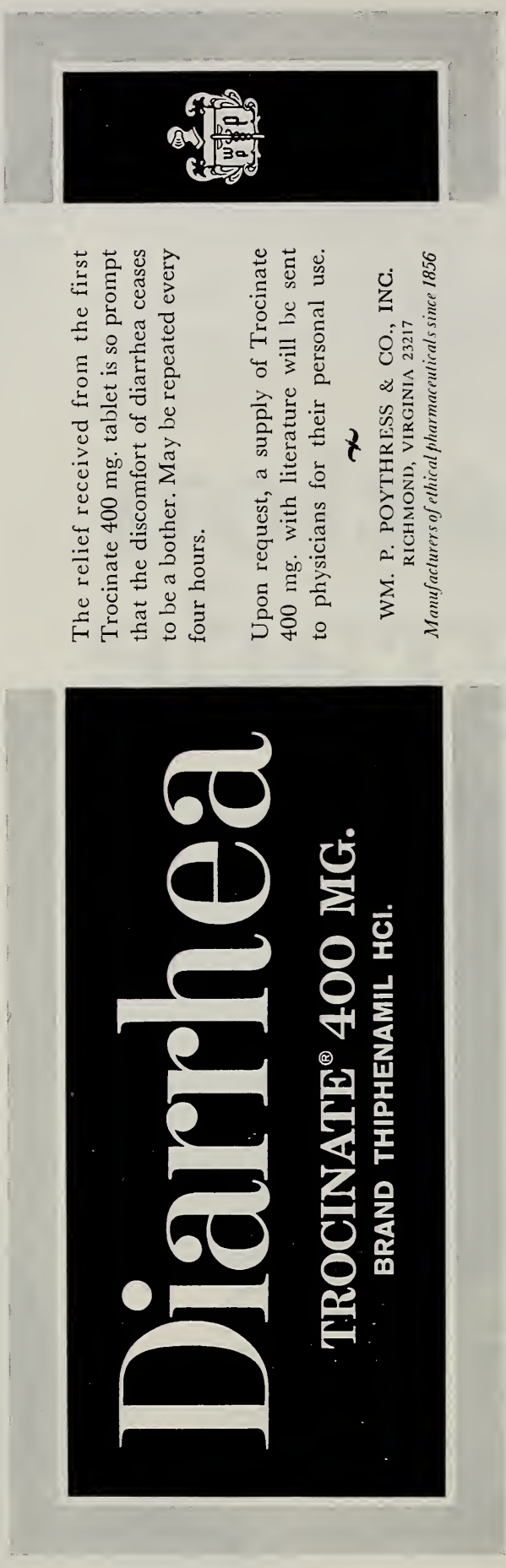
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SKF Establishes Medical Art Center

The establishment at the Philadelphia Museum of Art of an international medical art center of prints and related illustrative medical material with an accompaning research reference center has been announced by Dr. Evan H. Turner, director of the museum.

The complex, to be known as the Ars Medica Center, was made possible through a major grant from the Smith Kline & French Foundation, the educational and scientific trust of Smith Kline & French Laboratories of Philadelphia.

Development plans include the expansion of the museum's outstanding collection of prints and drawings relating to the medical sciences and the creation of a center for pictorial research in subjects pertaining to the history of medicine and allied professions such as dentistry, pharmacy, veterinary medicine, etc. Through an informational retrieval system, both the original and some non-original visual material such as photographic archives and slides will be readily accessible for reference, study, exhibition, and loan. It will be a unique service available only at the Philadelphia Museum of Art.

Administration of the Ars Medica Center will be under the direction of the Curator of the Department of Prints and Drawings, Kneeland McNulty.

The original collection, which was underwritten by Smith Kline & French in 1948, grew to comprise 132 prints, each chosen for its aesthetic value and for its portrayal of the essential aspects of medical iconography, as they have been reflected in graphic art through the ages. Many great artists included in the collection, which circulated for exhibition from 1952-1961 in 66 major cities in the United States, as well as Canada, Puerto Rico, and the British Isles, have illustrated the various categories of medical history and practice. The artists range from Schongauer, Dürer, Rembrandt, Goya, Bellows, Kollwitz, to leading contemporary American artists.

The high quality of this collection, the nucleus of the proposed program, is such that it is now regarded as one of the finest medical print collections in the United States. While there are three other public collections of graphic material on medicine and related fields in the United States, none include a plan to build a center such as envisioned at the Philadelphia Museum of Art.

Philadelphia—the birthplace of American medicine, endowed with excellent medical libraries and hospitals, an important center for medical education, research, and manufacturing—is the

ideal location for such an activity. To add a center for pictorial research in subjects pertaining to the whole history of western and eastern medicine to these riches will enhance the prestige of the museum and the City.

San Francisco Is AMA Meeting City

Demands placed upon the American health care system have made the health services industry the nation's fastest growing employment field, American Medical Association president Milford O. Rouse pointed out in a year-end report.

"Fifteen years ago it was the fifth largest employer, now it is third," said Dr. Rouse. "If present trends continue, it will become the nation's No. 1 employer by the early 1970s."

Few physicians need instruction in the facts concerning increasing demand.

In addition to the growing claims upon him by patients, medical society, hospital, civic affairs, and family, the physician faces his responsibility to himself to "keep up" with medical developments.

The year-around task of "keeping up" is manifested by the stack of medical journals, which is regularly attacked but often seems to be self-regenerating.

Once a year, the physician has an opportunity to spend the better part of a week doing nothing but "keeping up" at the world's largest medical meeting, the annual convention of the American Medical Association.

The 117th Annual Convention of the AMA will be held June 16-20 this year in San Francisco. The Civic Auditorium, War Memorial Opera House, and several nearby hotels will house the scientific program; the House of Delegates will meet in the Fairmont Hotel.

Approximately 600 scientific papers are to be presented, and more than 250 scientific exhibits will be on display as well as many industrial exhibits.

Among special presentations planned are four General Scientific Meetings on automobile accidents, health care planning, management of infectious diseases, and treatment of advance malignant disease.

Four General Scientific Sessions will be presented and the 23 Scientific Sections will offer programs individually, many holding joint meetings on subjects of common interest.

A full schedule of medical motion pictures is planned, as is a program of live color telecasting from a San Francisco-area medical center.

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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

March 1968

Dear Doctor:

Transplant procedures may become a matter of federal law, if S. 2882 by Washington state Sens. Jackson and Magnuson is enacted. The new measure, titled the Artificial Organs and Transplantation Act of 1968, would amend the Public Health Service Act to review medical, legal, social, economic, technical, and humanitarian aspects of organ transplantation.

> The proposal would also affect artificial kidney programs and provide regional centers for hemodialysis. Authority would be given USPHS to administer act through a national commission. An identical measure has been offered in the House of Representatives, H.R. 14937.

The reprehensible strike which turned Manhattan into a garbage dump had health overtones which did not make the headlines or TV reports. When Gov. Rockefeller decreed state take-over of New York City garbage collecting authority, he gave the distasteful job to State Health Officer Hollis Ingram. Board of Health was thus caught between union-city-state fight but did a good job.

The high costs of training a physician are sharply reflected in a recent study of medical school tuition rates. American Association of Medical Colleges reports that in 11 years, rates in public schools are up 200 per cent and in private schools, up 95 per cent. Top range annual rate is up to $1,800 in public schools and $2,500 in private institutions.

The American Association for Accreditation of Laboratory Animal Care has asked medicine's support of its voluntary program. New agency would assure best care for experimental animals, easing pressures for further federal controls. AMA supports program as a means of assuring scientific independence in research.

Part 1-B of Medicare continues to boom and zoom in Mississippi with over 20,000 claims in January, up 50 per cent over last quarter of 1967. Travelers Insurance, Mississippi carrier, paid almost 80,000 physicians' claims to the tune of nearly $4 million during last six months of 1967. Program is now approaching 180,000 claims per year. Present assignment rate is 57 per cent.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Mississippi Has Lowest Homicide Rate In South

Washington - A Public Health Service study of homicide rates shows that there's much less chance of being murdered in Mississippi than any other southern state from the Carolinas to Florida, and west to the river. The three-year study showed Mississippi to have a rate of 3.5 homicides per 100,000 for whites (against southern rate of 4.7) and 24.7 nonwhite (against southern rate of 29.3). Kentucky is bloodiest state for white murder with 5.7 rate, and Florida is worst for nonwhite homicide with 43.4 rate.

Football Injury Pattern Remains Stable

Chicago - Surveys show that football injuries during the 1967 season generally followed patterns of preceding years, except for a continuing decrease in dental injuries attributed to mandatory face guard. The knee is most commonly hurt, accounting for 18 per cent of mishaps. Hand injuries showed some increase, up to 12.5 per cent, and happened almost exclusively to interior linemen. Ankle injuries increased some, and more injuries occur in practice than in games.

Health Insurance Benefit Levels Are Studied

New York - The Health Insurance Association has reported a study of health insurance (commercial) benefits held by 68 million Americans who represent half of those under age 65 with coverage. Over 99 per cent have hospital benefits for 30 days and two-thirds had 70 or more days. Over half had hospital room benefits of $18, and 90 per cent had hospital extras up to $200. Seven out of 10 insureds had surgical benefit schedules of $300 or more. Insurance companies wrote 93 million hospital, medical, and surgical contracts during 1967.

PHS Checks Color TV's In Washington Area

Washington - The U.S. Public Health Service is surveying a sample of color television sets in the District of Columbia to determine levels of radiation emission from shunt regulator tubes. With full cooperation of TV manufacturing industry, PHS is checking up on modifications already made on sets with emission rate greater than level of 0.5 milliroentgens per hour. Among certain makes, one out of four sets had higher rates before modification program.

New Container Guards Against Radium Loss

Rockville, Md. - The National Center for Radiological Health has announced development of a new shipping container which guards against loss of radium needles. Project was undertaken because of loss of needles, many of which are still unrecovered. Container is an interior-exterior interlocking device and cannot be sealed until interior is safely closed.

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FOR WIDE BACTERIAL COVERAGE

Among the total of 661 patients (febrile and afebrile) who could be evaluated, the *clinical cure rate* was 92.2%*

FOR OPTIMAL PATIENT ACCEPTANCE

Three forms were used in the studies, prescribed according to the age and personal preferences of individual patients:

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Please see Brief Summary on next page.

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*Clinically cured included patients with complete symptomatic relief and those who had partial symptomatic relief within 72 hours with subsequent clinical cure.

803446

BRIEF SUMMARY FOR **Erythrocin®-Sulfas**

Indications For mixed infections which are more susceptible to the combination than to either agent alone. These may include susceptible gram-positive and/or gram-negative mixed infections. Not recommended in the treatment of infections expected to respond to full therapeutic doses of the antibiotic or sulfonamide alone.

Contraindications Known hypersensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, in premature or in newborn infants during first week of life.

Warnings As with other forms of sulfonamide therapy, use only after critical appraisal in patients with liver or kidney damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests when used intermittently or for long periods.

Precautions, Side Effects Use sulfonamides with caution in patients with a history of allergy, including asthma. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent; if encountered appropriate countermeasures (e.g. epinephrine, steroids, etc.) should be administered and the drug withdrawn. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. In prolonged therapy, or when high dosage is used, maintain an alkaline urine. If oliguria occurs, discontinue therapy. Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin; generally improved by reduction of dosage.

If overgrowth of nonsusceptible organism occurs, withdraw the drug and institute appropriate treatment.

Adverse Reactions Sulfonamide therapy may be associated with headache, nausea, vomiting, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, urticaria, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria. 803446

ABBOTT

Bama Computer Aids Heart Patients

A specially equipped computer monitoring system now in use at the University of Alabama Medical Center is enabling UA physicians and nurses to provide better intensive care to open-heart surgery patients during the critical post-operative hours. The IBM 1800 system senses, translates, and relays a steady stream of information on a patient's physiologic condition, thereby keeping attendants constantly informed of vital changes.

University Hospital officials say that the 1800, used in some 60 cases to date, improved patient care by insuring continuous and accurate recording of physiologic function, and, at the same time, has enabled health professionals to increase their efficiency with respect to time usage.

Dr. John Kirklin, chairman of the department of surgery, said, "The system has freed nurses from repetitious measurement and recording routines and has, consequently, given them more time to do what they are trained to do—administer superb patient care."

"Since it operates within limits which are preset by the physician, the computer is under our direct control," Dr. Kirklin said. "Also, there is never a break in the manner and frequency with which data on the patient's condition are taken and recorded."

Sensors linking the patient and the computer transmit information on temperatures, intra-arterial pressure, intracardiac pressures, chest drainage, and electrocardiographic signals. These signals are analyzed, translated, and displayed over closed-circuit television located at the patient's bedside, giving the physicians and nurses readings on heart rate, systolic blood pressure, average right and left atrial pressures, central body temperature, skin temperature, chest drainage, and volume of blood infused.

At five minute intervals, new readings are logged and compared with scientific criteria set by attending physicians. Any data revisions, plus messages to attendants, are displayed at the bedside. These messages may include recommendations to clean or adjust sensors, or to infuse blood. At the direction of the physician, the computer can automatically turn on a pump to add the required amounts of blood to the patient's blood stream.

"Our system now manages infusion of blood and soon will manage infusion of glucose and medications," Dr. Kirklin said.

Dr. S. Richardson Hill, Jr., dean of the Medical College of Alabama, said, "Other institutions have used computers to monitor a variety of patient functions. Our system includes the important feature of 'real work' in patient care. This improvement is in keeping with our goal of providing the best patient care with the most modern techniques available."

The new computer system also will be of value in the Medical College's program of education, Dean Hill said. "Students in the last years of medical training will have the opportunity to study advanced technology in patient care, and will be able to treat patients using these techniques. These students will devote more time to research and practice, since less of their time will be required for patient monitoring."

In addition to patient monitoring, the IBM 1800 is used for fundamental research. Data collected during patient monitoring are stored automatically for retrieval and analysis in related research projects. The computer system also is used for other, non-monitoring related projects.

Funds for the program originated in state and federal tax money appropriated through the Medical Center and the Alabama Vocational Rehabilitation Administration.

Pfizer Sets Med Technologist Workshop

The first in a series of workshops designed to instruct medical technologists in local and regional areas throughout the United States on the importance of quality control procedures in hematology has been launched by Pfizer Diagnostics, department of Chas. Pfizer & Co., Inc., at Park Ridge, Ill.

Approximately 50 medical technologists from hospitals and clinical laboratories in the Chicago area attended the special workshop entitled "Quality Control Systems Management in Hematology." It was conducted by Jack Cassorla, Technical Services Coordinator, and Arthur B. Hale, Product Marketing Manager for Hematology Quality Control Products at Pfizer Diagnostics.

The workshop sessions featured lectures by Mr. Cassorla and Mr. Hale on how quality control in hematology improves accuracy and precision, helps evaluate and maintain laboratory proficiency, and provides vital confidence limits for physicians. Pointers on how hematology laboratories can establish quality control procedures on a routine basis were also covered.



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the family's downed
Because the
G.I. bug's around

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warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
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Usual Adult Dose: One or two tablespoonfuls three times daily.
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in moderate hypertension and
poorly controlled mild hypertension
(when diuretics or sedatives are inadequate, for example)

1967 Tax Tables Are Still Effective

Although Social Security taxes have been increased by an extension of the wage base to $7,800 from the former $6,600 annually, there are no changes in the percentages of taxation upon employer and employee. The information is being published in response to numerous inquiries from physicians in January.

J. G. Martin, Jr., of Jackson, district director of the Internal Revenue Service said that employers should not expect a new issue of Circular E, also known as IRS Publication No. 15, but should make use of the Jan. 1967 edition which was previously distributed.

There has been no change in withholding tax rates for incomes, Martin said. The 1967 Circular E also gives rates for the withholding tax.

Endoscope Contract Goes to IIT

A contract for the development of five improved endoscopes to aid in early detection of cancer was announced today by the Cancer Control Program of the National Center for Chronic Disease Control, Public Health Service.

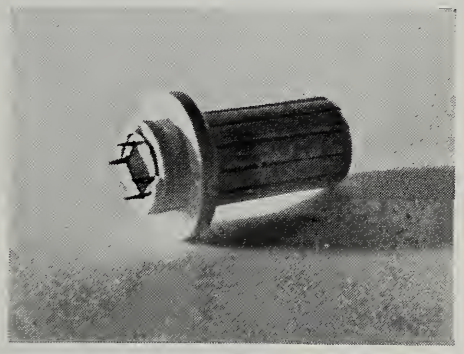
Dr. William L. Ross, Chief of the Cancer Control Program, said the contract for development of the instruments is budgeted at $149,222 and will require approximately 18 months. The contract was awarded to the IIT Research Institute, an affiliate of the Illinois Institute of Technology in Chicago.

The instruments will be flexible fiber optic probes for viewing the throat, larynx, bronchial tubes, stomach and a portion of the colon which will enable doctors to view the interior of the body without performing surgery. Cancers in these 5 sites will cause almost 100,000 deaths this year.

The contract calls for the development of new synthetic fibers instead of glass to transmit light around curves in the body organs. The probes also will have a mechanical system allowing maneuverability and control by the examiner. Though glass fibers are flexible, they are not flexible enough to prevent occasional breakage when probes are flexed into sharp bends. Poly-Optics Systems, Inc., Santa Ana, California, will join IITRI in fiber development.

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.

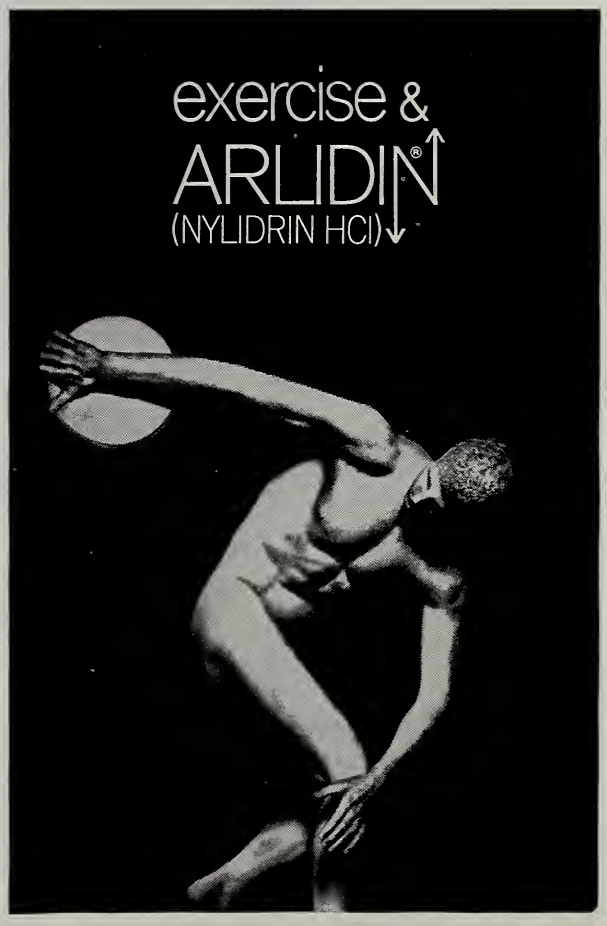


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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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"Upper respiratory infection! I thought everything was a 'virus' these days?"

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
March 1968, Vol. IX, No. 3

ORIGINAL PAPERS

Heart Transplantation

J. D. HARDY, M.D.; H. H. TIMMIS, M.D.;
C. M. CHAVEZ, M.D.; P. H. LEHAN, M.D.;
H. K. HELLEMS, M.D., and L. W. FABIAN, M.D.
Jackson, Mississippi

Investigation of heart transplantation at the University of Mississippi School of Medicine began in 1956. In 1964 a chimpanzee heart was transplanted in a patient in shock from terminal cardiac disease. It functioned for several hours before the patient died. Today, write the authors, the capability for clincial heart transplantation is fully developed at the medical center, and the transplant team remains in a constant state of preparedness. Criteria for an acceptable donor and recipient are discussed as well as the essential features of operative and postoperative management.

THE SUCCESSFUL APPLICATION of clinical heart transplantation, climaxing years of experimental investigation, has captured the attention and interest of many within and outside of the medical profession. It is, perhaps, not generally appreciated that parallel progress in tissue transplantation and cardiac surgery, derived from the work of countless investigators, resulted in the accomplishment of this remarkable feat.

Shortly after open heart surgery with cardiopulmonary bypass became an accepted clinical modality, the technical feasibility of cardiac transplantation was tested here and elsewhere. Although anastomosis of the many communications to the heart was tedious, there were several instances of short term survival. At the same time, renal homotransplantation was being performed experimentally at many medical centers and the first few successful renal homotransplants were already being observed for the human response to homologous renal tissue.

During the succeeding 10 years, vast experience was gained in temporary, total replacement of cardiopulmonary function with the heart-lung machine on one hand, and in the management and response of patients with renal hemotransplants on the other. With the former, refinements of surgical technique and improved methods of cardiopulmonary bypass led to a progressive decline in operative mortality. With the latter, appreciation of patient selection, tissue compatibility, preservation of the transplant and improved methods of immunosuppression resulted in steadily more consistent success. As the technical, physiological, and immunological obstacles were

From the Departments of Surgery, Medicine, and Anesthesiology, University of Mississippi School of Medicine.

overcome, it was inevitable then that the marriage of these two concepts of treatment for terminal disease would culminate in human heart transplantation.

Investigation of heart transplantation at the University of Mississippi Medical Center began in 1956 with the work of Webb and Howard, who successfully performed combined homologous and autologous heart and lung transplants in the canine with survival up to 22 hours[1] (Figure 1). Viability of the transplant during transfer was augmented by a technique of cardiac hypothermia developed by the investigators.[2] Refinements of surgical technique resulted in the more complex transplantation of the canine heart alone one year later[3] (Figure 2). Cervical implantation of the puppy heart into the adult dog by Lee and Webb in 1958 provided an experimental model for the study of cardiac transplant metabolism and supplied information which potentiated longer survival in subsequent orthotopic transplants.[4]

Following the description elsewhere of a transatrial suture technique which greatly augmented the speed and facility of orthotopic heart transplantation, Hardy and Webb proceeded to investigate and master this method in the dog.[5] In 1963, Hardy *et al.* initiated a study of bovine heart transplantation and reported these results at the Sixth International Transplantation Congress.[6] A technique of retrograde perfusion of the coronary sinus was successfully used to preserve the donor heart during implantation and was subsequently employed in the first clinical transplantation of a heart.

EXPERIMENTAL SERIES

Girded with the experience of over 200 experimental heart transplantations in the dog, calf, and chimpanzee, coupled with the organization of a well-disciplined transplant team, Hardy and his group prepared for the first human heart transplantation.[7] The favorable combination of a suitable recipient and a satisfactory donor remained elusive and several potential recipients succumbed without the benefit of a transplantation attempt.

When a patient in shock from terminal cardiac disease was presented for transplantation in January, 1964, a donor was lacking. Aware of the remarkable results obtained elsewhere with the chimpanzee kidney in human recipients, the transplant team decided to use a chimpanzee heart. The heterotransplant functioned promptly and for several hours but was unable to support

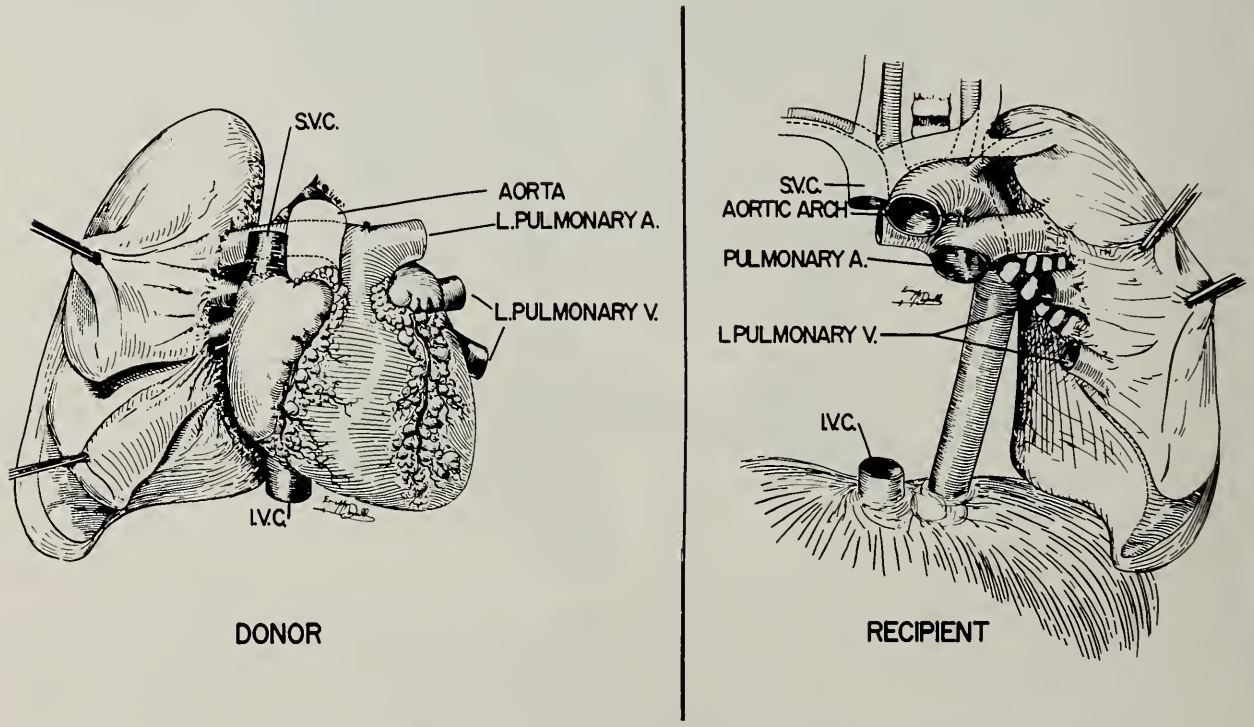


Figure 1. Combined heart-lung transplants were performed initially to limit the number of vascular anastomoses.

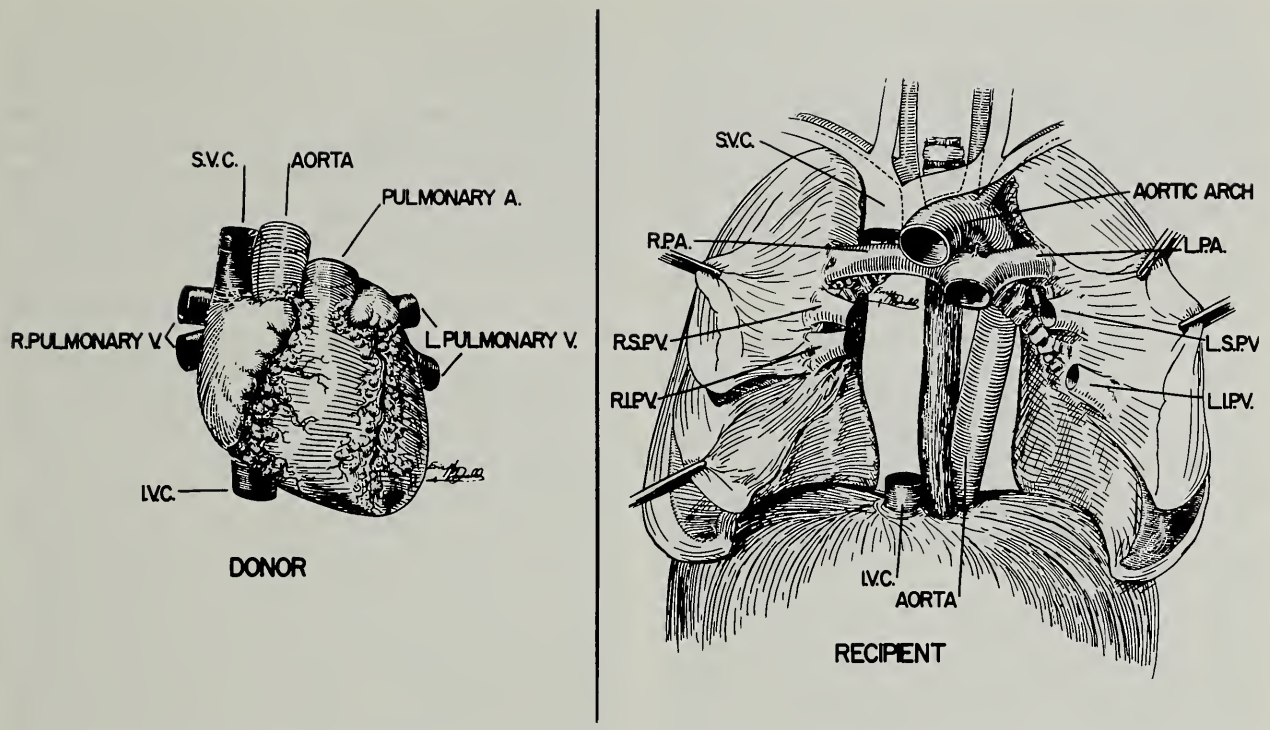


Figure 2. Advances in cardiopulmonary support and preservation of the heart during transplantation provided a sufficient period for anastomosis of all vascular communications with the heart.

the circulatory load indefinitely because of its small size.

However, the world wide interest and discussion which this therapeutic effort engendered prepared public opinion for the broad acceptance which current human heart transplantation has met. In the meantime, the transplant team headed by Hardy continued to investigate heart transplantation in the experimental laboratory, as well as the transplantation of other organs including liver, lung, uterus, and stomach. The results of this broad experience have appeared in many publications.[8-12]

The experience which was acquired with over 2,000 clinical renal allografts firmly established the concept of organ transplantation as a method of replacing vital function with a reasonable hope of success. The capability for transplantation of the heart, in turn, has existed for several years. However, clinical heart transplantation has been delayed for at least four reasons.

TRANSPLANT PROBLEMS

First, unlike renal transplantation, there is no method at present by which total cardiac function can be supplied artificially while the recipient is awaiting a suitable donor. On the other hand, the simultaneous presence of a recipient and donor fulfilling both medically sound and ethical criteria is at least propitious and relatively uncommon. Since the heart is an unpaired organ, the use of a living donor for transplantation is, of course, out of the question.

ALTERNATIVES IN FAILURE

Second, in the event of transplantation failure there is no method of supporting the recipient other than by another heart transplantation. Consequently, death of the recipient rather than return to temporary artificial support is inevitable. Third, the recipient for heart transplantation by definition is a much less healthy individual than his renal recipient counterpart, who has been prepared by chronic dialysis. The risk involved in transplantation as related to the recipient's response to operative trauma and immuno-suppressive therapy is therefore increased. The overall result is that heart transplantation as a therapeutic modality has been embraced with less enthusiasm than renal transplantation from the standpoint of the recipient.

Fourth, a potential recipient who responds to vigorous medical management and approaches the general health status of a prepared renal recipient automatically excludes himself as a recipient for heart transplantation by our present

criteria. The recipient must be approaching an evident terminal state and at the same time his condition must be such that death is more than just a few hours away. It is evident from our own experience, and that of others recently acquired, that for successful heart transplantation, the recipient should probably have a life expectancy of from one to three weeks.

At present, patients with two forms of cardiac disease constitute the most likely reservoir of heart transplantation recipients, namely those with irreversible heart failure resulting from advanced arteriosclerotic heart disease and a history of one or more myocardial infarctions and those with irreversible heart failure due to a progressive cardiomyopathy. In many instances both diseases afflict those in the younger age group, often without serious associated disease or associated organ dysfunction. Patients with acquired valvular disease, on the other hand, are usually poor candidates for transplantation because severe pulmonary hyptertension and a reduced pulmonary reserve, which complicate convalescence critically after open heart surgery, are commonly present. Furthermore, valve replacement would be first considered in such patients.

RECIPIENT'S MEDICAL PROGRAM

Initially, the medical program of a potential recipient will be scrutinized, and if necessary altered, to determine whether any measures other than heart transplantation can be used to improve his prognosis. After maximal clinical improvement is achieved, cardiac dysfunction will be documented objectively by cardiac catherization. If, in the firm opinion of at least two cardiologists and two cardiac surgeons, the patient's prognosis is less than three weeks and no medical contraindications are present, cardiac transplantation will be offered. The patient and his family will be fully informed concerning the status of his heart disease, its prognosis, the risks of cardiac transplantation and its possible complications within the limits of our present knowledge. Informed consent will be documented in writing by the patient and his next of kin and attested by two witnesses not associated with the transplant team. The search will then begin for a suitable donor.

In summary, a recipient for heart transplantation at the University of Mississippi Medical Center must be an adult less than 60 years of age with terminal cardiac disease probably due to severe, chronic arteriosclerosis or a cardiomyopathy. Although his prognosis must be less than four weeks, he must not be in peripheral vascular collapse due to his cardiac disease. He must be free of serious associated diseases such as collagen disease or remote infection, as well as serious dysfunction of the lungs or liver resulting from cardiac disease. Informed consent must be given in writing by the recipient and his next of kin.

DONOR SELECTION

The extensive experience with cadaver donors for renal homotransplantation is applicable in large part to the selection of a donor for heart transplantation. In general, most satisfactory results have been obtained with the organs of patients dying of brain damage due to trauma or cerebral vascular accidents. Peripheral vascular collapse usually does not play a dominant role in their early deterioration and a period often follows which allows blood and tissue typing and a thorough physical and laboratory examination to rule out systemic illness or infection. The younger age group is preferred; however, potential donors less than 45 years of age are acceptable.

The workup of a potential donor will begin at the onset of respiratory arrest or at that point when controlled ventilation is required to sustain viability. After electroencephalographic activity has ceased, contact will be made with the family by a member of the transplant team requesting the heart for transplantation should death ensue. Permission will also be requested to begin circulatory support by peripheral cannulations with the pump oxygenator when peripheral vascular collapse intervenes. Permission will be documented in writing and countersigned by at least two witnesses not associated with the transplant team. No further action will be taken with the donor until death is pronounced by his private physician.

AGE AND HEALTH CRITERIA

In summary, a suitable donor must be less than 45 years of age and must have respiratory and circulatory arrest, and no indication of electroencephalographic activity. He must be free of cardiac disease, systemic illness or infection. There must be blood type compatibility with the recipient and at least a moderate degree of tissue compatibility by the leukoagglutin technique of Terasaki.

Materiel necessary for heart transplantation, including two pump oxygenators, appropriate tubing, cooling equipment and recording apparatus,

are in a constant state of readiness. All members of the transplant team will be placed on standby when a patient is judged a candidate for transplantation. An alert will be declared when a potential donor becomes available and, depending upon the state of neurological deterioration, personnel will be advised concerning the probable imminence of transplantation. The transplantation procedure will take place in adjacent operating rooms which are the usual sites of open heart surgery and the operation, consisting of removal of the recipient heart, procurement of the donor organ, and implantation of the allograft into the recipient, will be documented by kodachrome cinematography and still photographs. The transplantation technique, which is illustrated diagrammatically in Figure 3, is described below.

Immediately after the donor is pronounced dead, partial circulatory support by the Drew technique will be instituted, i.e.. cardiopulmonary bypass via the femoral artery and both femoral veins. As the body temperature is being lowered to 20°C. with a heat exchanger, the heart will be exposed rapidly through the median sternotomy approach and the right atrium cannulated with a single large bore catheter to allow more effective venous drainage into the heart-lung machine. The ascending aorta and innominate artery will then be mobilized and the left ventricle vented to avoid distention. Following cannulation of the innominate artery with an extension from the arterial line of the heart-lung machine, the aorta will be cross-clamped distal to the innominate to discontinue total circulatory support and coronary circulation will be maintained by perfusion directly into the aortic root through the innominate artery at a reduced pump output.

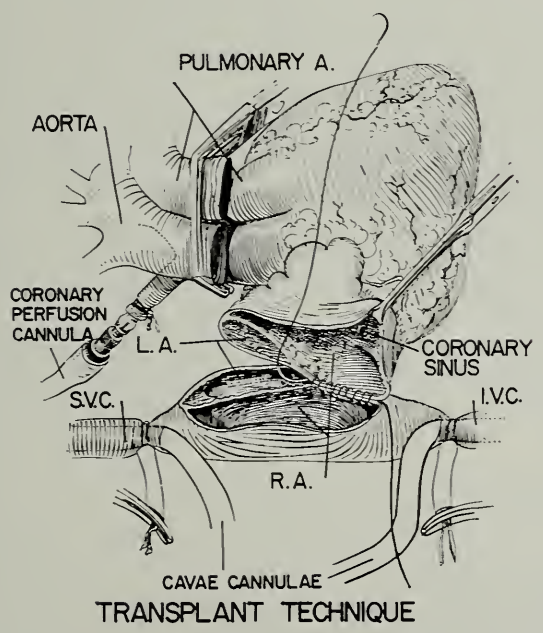


Figure 3. The operative technique for clinical heart transplantation consists of serial anastomosis of the atrial cuffs, main pulmonary artery and ascending aorta during cardiopulmonary bypass and hypothermic perfusion of the donor organ.

HEART IMPLANTATION

When preparation of the recipient has been completed, the donor heart will be completely mobilized by dividing the aorta distal to the aortic clamp, the pulmonary artery distal to its bifurcation and the atria just proximal to the ostia of the cavae and the pulmonary veins. Coronary perfusion will be momentarily interrupted as the transplant is transferred to the recipient's chest cavity and resumed after attachment of the innominate arterial line to a pressure sensitive independent coronary perfusion apparatus. Cardiac hypothermia at 20°C. will be continued during implantation of the donor heart.

While the donor organ is procured, the recipient will be prepared simultaneously under halothane anesthesia in an adjacent operating room. During continuous monitoring of systemic arterial and venous pressures, the electrocardiogram and the electroencephalogram, the heart will be exposed through the median sternotomy approach and preparations made for cardiopulmonary bypass. The cavae will be cannulated through atriotomies just proximal to the caval ostia to channel cardiac venous return into the pump oxygenator while blood is returned to the recipient through a cannula in the external iliac artery.

ANASTOMOSIS METHOD

After total bypass is instituted, the aorta will be cross-clamped proximal to the innominate artery and the heart excised, leaving generous cuffs of ascending aorta, main pulmonary artery, right and left atrium and atrial septum. The allograft will be positioned in the recipient chest cavity, its cut edges trimmed appropriately and anastomosis begun of the left atrium, septum, right atrium, pulmonary artery and aorta in that order. All suture lines will be backed with Teflon felt for hemostasis. Prior to release of the aortic clamp, every precaution will be taken to remove air from the cardiac chambers and great vessels.

Coronary perfusion, which is temporarily interrupted by completion of the aortic suture line, will resume with release of the aortic clamp after

which the heart will rapidly warm and begin to fibrillate or beat spontaneously. Following restoration of an adequate beat supported if necessary with isoproterenol, cardiopulmonary bypass will be gradually discontinued and the operation completed as in other "open heart" surgery with every care being taken to obtain complete hemostasis. The recipient's heart will be submitted to the Pathology Department for complete gross and microscopic study.

The recipient will be moved to a sterile bed but will remain in the operating room for 24 to 48 hours for intensive care, continuous monitoring of all vital signs and protective isolation. He will then be transferred to the Clinical Research Center where protective isolation and intensive care will be continued. Cardiac function will be appraised by serial cardiac output determinations and pulmonary function evaluated by repeated measurements of blood pH, pO_2, and pCO_2. Maintenance of acid-base and electrolyte balance will be supplemented by blood and serum analyses at appropriate intervals to guide replacement therapy.

Permanent records of the electrocardiogram will be collected to be used as references for the diagnosis of rejection later in the postoperative course. Cortisone (Prednisolone) and azathioprine (Imuran) will be used for immunosuppression, possibly supplemented with mediastinal radiation. Therapy will be adjusted according to the white blood cell-platelet response. Information concerning the patient's response will be released to the press at appropriate intervals solely by the Office of Public Information.

SUMMARY

Investigation of heart transplantation began at the University of Mississippi Medical Center in 1956 and has been uninterrupted since that time. The rich experience which was obtained with dogs, calves, and lower primates formed the background for the first human heart transplantation in 1964. The capability for clinical heart transplantation is fully developed at the center and the transplant team remains in a constant state of preparedness by frequent experimental heart transplantations. Criteria for an acceptable donor and recipient are discussed as well as the essential features of operative and postoperative management.

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VIETNAM SOLUTION

Some observers say that President Johnson has been using poor diplomacy on the Vietnamese dilemma. They point out that Ho Chi Minh should be advised to consider Japan and West Germany, both defeated by the United States in World War II. They are two of the four most prosperous nations in the world today.

The One Minute Direct Reacting Bilirubin: A Neglected Liver Function Test

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Because of the lack of agreement upon the normal laboratory values for the serum bilirubin tests, it was decided to study a number of these tests in the Mississippi Baptist Hospital laboratory. The objective was to see whether it was possible to arrive at any practical and informative conclusion. The author reports the conclusion of the study, which lasted six months and involved 420 tests.

THE SERUM BILIRUBIN TESTS have evoked much controversy among clinicians and clinical pathologists. This controversy which derives from the disagreement upon the normal laboratory values has generated a lack of confidence in these tests. The great majority of physicians, therefore, rely on other liver function tests for their diagnosis.

The total bilirubin (TB), unless it reaches a level above 5 mg. per cent, is a poor liver function test, first because it does not tell whether the cause of increased bilirubin is prehepatic, intrahepatic, or posthepatic; second, because there is not yet complete agreement as to what constitutes the upper limits of normal. As a matter of fact, there is no such limit in this test. The direct reacting bilirubin test, the most accurate liver function test available, is almost completely neglected. Undoubtedly, this stems from the fact that here there is no agreement on the performance of this test which depends on the timing, the timing varying from 1 to 5 minutes and in some laboratories going as high as 30 minutes which, of course, is sheer nonsense.

I thought then that the best way to approach this problem was to study a number of bilirubin tests in our laboratory to see whether it was possible to arrive at any practical and informative conclusion.

Before embarking on this survey I wrote to Dr. Watson[1] of the University of Minnesota Medical School in order to have first-hand information on this subject. Dr. Watson has always been a strong advocate of the one-minute direct reacting bilirubin (1′DRB) as a highly accurate method for detecting early liver impairment. I asked him whether there had been any change in his attitude toward this test. He replied, "We have published evidence that the prompt reacting bilirubin at one minute is better correlated with the conjugated bilirubin than any other value depending upon time."

Encouraged by this statement, I asked our technicians that any time they received a request for bilirubin, which with a few exceptions was always for TB, to run also as a parallel test the 1′DRB. In this way we were able over a period of six months to collect 420 tests, namely 420 TB and 420 1′DRB tests. From this survey we excluded those tests in which the TB when accompanied by one of more abnormal liver function tests was above 1.50 mg. per cent, taking this figure as the most accepted although quite arbitrary upper limit of normal. Four hundred of these tests were considered to be within normal limits because the 1′DRB and other liver function tests were normal. Twenty of these tests, with a TB below 1.5 mg. per cent, were considered abnormal because the 1′DRB and the other liver function tests were abnormal.

Table 1 summarizes the results of this survey.

Read before the quarterly meeting, Mississippi Baptist Hospital Medical Staff, July 18, 1967.

It is evident that it is an error to take the figure 1.50 mg. per cent of TB as the upper limit of normal since higher values were found in normal livers during our survey. Quite a few will not accept 2.73 mg. per cent TB as normal, but the patient with this high TB had all other liver function tests normal. He could have a larvate, smoldering type of hemolytic anemia, but then we trespass into the field of hematology: here we are concerned with liver functions.

UPPER LIMIT OF TB

Taking the figure of 1.5 mg. per cent as upper limit of normal for TB, we assume that all values below this figure reflect a normal liver function, and this of course is an error, as we shall see shortly. Many laboratories place their upper limit of normal for TB at 1.20 mg. per cent, and this, too, leads to errors of interpretation since one assumes that all values above 1.20 are abnormal and all values below 1.20 are within normal limits, which is not true; and so we are as confused as we were with the 1.5 mg. per cent figure. Concluding, the range of normal values 0.10 mg. per cent-2.73 mg. per cent for TB is too wide to be of any diagnostic assistance. In addition, if we distribute our observations on a curve it will turn out asymmetrical or "skewed" since the median, mean, and the mode do not coincide.

Let's look now at the results of the 1'DRB determinations. One can see immediately that this is a more precise method of measurement; first, because the range between low and high values is very narrow. Secondly, if we plot the values on a curve we obtain an almost normal frequency distribution curve where the mean, median, and mode almost coincide. But what is most important of all is that in 400 normal liver function tests the highest value of 1'DRB never exceeded 0.26 mg. per cent. It is interesting to note that the figure of 0.26 mg. per cent was not pre-selected but emerged from our survey.

Now let us see whether or not we can establish the lower limits of abnormal for these two tests.

TABLE 1

BILIRUBIN VALUES IN 400 NORMAL LIVER FUNCTION TESTS (MALLOY-EVELYN METHOD)

Range of normal values	
1'DRB	TB
0-0.26 mg.%	0.10-2.73 mg.%
Mean: 0.11	Mean: 0.62
Lower limits of abnormal values	
1'DRB	TB
0.35 mg.%	1.51 mg.% (?)

TABLE 2

ABNORMAL LIVER FUNCTION TESTS WITH NORMAL TOTAL BILIRUBIN VALUES

No.	*Patient*	*1'DRB*	*TB*	*SGOT*	*APh*	*Diagnosis*
1.	G.H.	0.55	1.03	63	29	Liver abscess
2.	W.M.	0.45	1.13	250		Hepatitis
3.	E.W.	0.35	0.65	25	20	Hepatomegaly
4.	N.C.	0.45	1.13	118	21	Hepatitis
5.	C.H.	0.35	.90	108		Decompensated chronic heart disease
6.	R.S.	0.55	1.23	138		Cirrhosis
7.	P.S.	0.35	1.13		31	Metastatic carcinoma
8.	M.S.	0.45	1.03	182	33	Hepatitis
9.	J.T.	0.35	0.60	97		Lymphosarcoma
10.	A.S.	0.45	0.93	273	16	Infectious mononucleosis
11.	J.B. (4-17-67)	0.93	1.13	11	3.5	Telepaque
	(4-19-67)	0.10	0.74			

If we take 1.50 mg. per cent as the upper limit of normal for the TB, we have to take 1.51 as the lower limit of abnormal for this test which, for the reasons previously told, is far from being correct. The results are quite different in the 1'DRB. In all cases of liver impairment in which one or more of the other liver function tests was abnormal the 1'DRB was never below 0.35 mg. per cent. As one can readily see, between the upper limit of normal of 0.26 mg. per cent and the lower limit of abnormal of 0.35 mg. per cent there is no trailing of figures but an empty space that I call the physician's safety gap for the diagnosis of early liver impairment.

SERIES OF CASES

In Table 2 there are presented 10 of our 20 cases in which the liver function tests were abnormal when the TB was below 1.50 mg. per cent. The column of TB values clearly shows how poor and misleading is this test in detecting early liver disease since values as low as 0.60 are accompanied by abnormal liver function tests including the 1'DRB. On the other hand, the column of the 1'DRB values shows that any values of .35 or

above indicate abnormal liver functions in spite of the fact that the TB was far below 1.5 mg. per cent. Case No. 11 shows how the Telepaque pills given in the evening affect the 1′DRB when the test is done on serum collected the following morning. The values became normal 48 hours after Telepaque ingestion. This temporary increase of 1′DRB is due to the fact that the Telepaque is conjugated in the liver with the glucuronic acid and then excreted through the bile ducts, thereby creating an excretory overload in which the simultaneous excretion of 1′DRB is somewhat impeded. It is of interest to note that the Telepaque ingestion causes also a retention of BSP which could signify that the 1′DRB is as sensitive a liver function test as BSP.

LIVER IMPAIRMENT INDICATION

Is the 0.35 mg. per cent 1′DRB an absolute indication of liver impairment? The answer is "yes" if hemolytic disease has been ruled out a priori. In case of hemolytic disorders, increase of direct reacting bilirubin is to be expected and does not denote abnormal liver function, and here is the reason. Not long ago it was thought that the direct reacting bilirubin present in the serum of normal individuals was the result of a leakage through the bile canaliculi into the blood stream of this water-soluble pigment.

We now know that the bilirubin is excreted after conjugation in the liver with monoglucuronic and diglucuronic acids. About 85 per cent of this conjugated bilirubin is diglucuronide bilirubin and the remainder is monoglucuronide bilirubin. It is well established now that the conjugation of the indirect reacting bilirubin takes place also in the extrahepatic reticuloendothelial system and that most of the monoglucuronide bilirubin originates in this extrahepatic territory. Thus, what we actually measure in the 1′DRB test is chiefly this bilirubin monoglucuronide.

In hemolytic diseases there is, of course, an increase of production of indirect or free bilirubin and, therefore, for the reasons just told, also an increase of the bilirubin monoglucuronide which passes directly from the reticuloendothelial system into the plasma with an increase of the 1′DRB fraction. Now the question arises: given an increase of the 1′DRB to or above 0.35 mg. per cent, how one can tell whether this increase is due to liver damage or to an hemolytic disorder?

This question is rapidly settled when the TB is above 5 mg. per cent, since any amount of TB above this figure indicates liver damage, obstruction or both. The great excretory capacity of the liver, found to be directly proportioned to the square of the plasma bilirubin concentration, accounts for the fact that the TB in hemolytic disorder never exceeds 5 mg. per cent. This, of course, does not apply to the newborn whose liver has not yet reached full maturity.

TABLE 3

$$\frac{1'DRB}{TB} \times 100 = <20$$

1′DRB <20% TB

Example 1: P. WW 1′DRB:0.52 TB:4.3

$$\frac{0.52}{4.3} \times 100 = 12$$

1′DRB = 12% TB

Example 2: P. KH 1′DRB:3.5 TB:28.6

$$\frac{3.5}{28.6} \times 100 = 12$$

1′DRB = 12% TB

Example 3: P. No. 8 1′DRB:0.35 TB:1.13

$$\frac{0.35}{1.13} \times 100 = 30$$

1′DRB = 30% TB

In those instances in which the TB is below 5 mg. per cent a differential diagnosis between hyperbilirubinemia due to liver damage and hyperbilirubinemia due to hemolytic disease is possible if the ratio of 1′DRB to TB is taken into account since in hemolytic disease the 1′DRB is always less 20 per cent of TB. As shown in Table 3 this ratio can be expressed as a fraction or directly as a percentage. The 20 per cent figure has been recommended by Dr. Watson; Cantarow and Trumper[3] prefer the 15 per cent figure, thus making this rule more rigid.

In Table 3 there are three examples illustrating the ratio of 1′DRB to TB. In Example 1 the patient suffered multiple injuries in an automobile accident which resulted in numerous massive muscular hematomas. This massive hemoglobin breakdown is comparable to the injection of hemoglobin into a healthy individual. Example 2 is a case of a newborn with erythroblastosis fetalis and Example 3 illustrates the Case 8 of Table 2 of a severe liver damage due to metastatic carcinoma.

ILLUSTRATIVE CASE

A case of peculiar interest for the evaluation of the 1′DRB is that presented in Table 4. This patient, who has had two previous admissions for cholecystectomy (Feb. 5, 1966) and appendectomy (April 10, 1967), was admitted on April 29, 1967, because of profuse uterine bleeding of a week's duration that massive doses of hormones failed to control. The alkaline phosphatase, SGOT

and BSP tests showed abnormal values, but the 1'DRB was within normal limits. After admission the patient continued to bleed.

The internist, called in consultation, advised hysterectomy which was done on May 7, 1967. He thought that in spite of seemingly abnormal liver function tests these did not reflect a true liver impairment because of a normal 1'DRB. As an additional test to rule in or out liver damage we performed an LDH determination; the total LDH was increased to 710 units. The isoenzyme fractionation by the heat method of Wroblewski showed that the LDH 5 fraction (liver and muscle isoenzyme) was well within normal limits and that the increase was in the LDH 1 fraction (heart, renal cortex and erythrocyte isoenzyme).

The fact that the patient recovered promptly and completely after the hysterectomy, done under general anesthesia, is a clinical proof that this was not a case of liver damage, thus, once more pointing to the high diagnostic value of the 1'DRB.

SIGNIFICANCE OF OTHER TESTS

This survey gave us the opportunity to study the diagnostic significance of the other liver function tests routinely used in the laboratory. Our judgment on these tests is much in agreement with the recommendation given by Dr. Gambino,[4] chairman of the Council on Clinical Chemistry of the American Society of Clinical Pathologists. We came then to the conclusion that the liver function tests can be divided into two groups as shown in Table 5.

Beginning with Group A, the prothrombin time-Vitamin K test is a true liver function test since the prothrombin is manufactured in the liver in the presence of Vitamin K. Failure of Vitamin K to correct a prolonged prothrombin time indicates liver damage.

The BSP test, undoubtedly the most sensitive test for liver function, has its limitations and drawbacks. To begin with, the same amount of dye is injected in each patient, based on the incorrect assumption that each subject has 50 ml. of plasma per kilogram of body weight. In shock, hemorrhage, congestive failure and pregnancy in which hepatic blood flow may be reduced there will be false BSP retention. In the obese, because fat has little blood supply there is decreased plasma volume per unit of body weight and, therefore, again, a false BSP retention is expected. The same is true in the elderly because of physiological changes.

TABLE 5

A—Key Tests
1. One-minute direct reacting bilirubin
2. SGO-Transaminase
3. Alkaline phosphatase
4. Sulfobromophthalein (BSP)
5. Prothrombin Time—Vitamin K
B—Unnecessary Tests
1. Urine bilirubin
2. Urine urobilinogen
3. Cephalin-cholesterol flocculation
4. Thymol turbidity
5. Icterus index

An absolute contraindication to the BSP test is the elevation of the 1'DRB which is always associated with an elevated BSP retention. The physician should be aware of the fact that the BSP test involves the intravenous injection of a dye, with its hazards of tissue necrosis and vein thrombosis of the site of injection in case of extravasation and of possibility of toxic and allergic reactions. The sole indication for BSP test is represented by the rare case in which all other liver function tests are within normal limits but the physician still suspects a liver impairment.

The alkaline phosphatase test is highly accurate

TABLE 4

W.W., AGE: 43—OBESE, DIABETIC, HYPOTHYROID

Admissions	*1'DRB*	*TB*	*CF*	*AlkP*	*SGOT*	*ThyT*	*BSP*	*Chol*	*LDH*		*Urine Prot*
II. 4/10/67 ..								370			3+
III. 4/29/67 ..	0.26	0.83	0	10	250	1.8	32				4+
I. 2/ 5/66 ..		0.45		3.7	33			440			1+
5/ 3/67 ..	0.26	0.83			182				LDH_1	500	
5/ 7/67 ..					93			710	LDH_{2-3-4}	110	
5/ 9/67 ..	0.10	0.74			67				LDH_5	100	

in detecting early liver damage provided other sources for the increase of this enzyme are ruled out, such as bone, placenta, intestine. A comparative evaluation of alkaline phosphatase and direct bilirubin is useful in differential diagnosis between extrahepatic and intrahepatic obstruction.

In intrahepatic obstruction due to metastatic carcinoma, liver abscess and intrahepatic stones, the alkaline phosphatase is elevated out of proportion to the elevation of 1′DRB. In Case 8 of Table 3 we were able to predict the operative finding at the exploratory laparotomy.

This peculiar behavior of alkaline phosphatase has been an enigma until a few years ago when it was demonstrated that the cells lining the bile ducts and the canaliculi and the liver cells at the sinusoidal surface contain alkaline phosphatase. Therefore, any time there is focal damage of these structures the alkaline phosphatase enters the plasma and its level is increased.

The SGOT is elevated in about a dozen conditions other than liver disease, but its high accuracy in detecting liver damage has made it the enzyme of choice in screening for acute or chronic liver disease. It has completely replaced the SGPT which in case of chronic liver disease is frequently normal. The invariable extremely high elevation of SGOT in viral hepatitis makes this test diagnostic for this condition.

The 1′DRB has already been dealt with at length and there is not too much left to be added; suffice here to state that according to our own experience the 1′DRB is the most specific liver function test available. Going through the second group, the urine bilirubin has no diagnostic significance since the renal threshold for conjugated bilirubin varies from 0.7 to 3 mg. per cent, so when the direct bilirubin is low, its elevation is detected much earlier in the serum than in the urine, and when it is above 2 mg. per cent the patient is so "jaundiced" that there is no need for this test.

The urine urobilinogen was recommended a long time ago for early detection of liver damage, but this test is now obsolete since serum tests are much more precise and allow a much earlier diagnosis than the urine urobilinogen. The urine urobilinogen as a test for detection of hemolytic disorders has been completely replaced by hematological tests. Finally, this test is not reliable to differentiate between partial and complete obstruction of the common duct.

A plasma direct bilirubin, when reaching high levels, soaks the intestinal mucosa and oozes into the intestinal lumen to be then transformed into urobilinogen. Thus, in such case, detection of urobilinogen in the urine gives the false impression that the common duct is still patent. The only diagnostic test which enables us to tell apart a complete from an incomplete common duct obstruction is an exploratory laparotomy.

The cephalin cholesterol flocculation and the thymol turbidity tests are based on the alteration of the globulin-albumin ratio of the serum and, therefore, they are not liver function tests. For those who may find it difficult to abandon the cephalin flocculation test, it may be of interest to know that the Columbia Presbyterian Medical Center had stopped doing this test in 1966. Incidentally, this test was developed by a Dr. Hanger working in the laboratory of the Columbia Presbyterian Medical Center.

Finally, the icterus index, if the patient has not eaten spinach, carrots or egg yolks, indicates hyperbilirubinemia; but it tells us only how yellow the patient is and this can be done in a much simplier way by looking at the patient's skin and sclerae. ★★★

1100 North State St. (39201)

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NEUTER GENDER

Said one professor to another: "Who was that lady I saw you out with last night?"

"That was no lady," replied the first professor. "That's our new sociology instructor who just got his master's degree at Yale."

Radiologic Seminar LXXI: Ewing's Tumor

JAMES D. MASSIE, M.D.
Jackson, Mississippi

EWING'S TUMOR, originally called "diffuse endothelioma of bone," was first described in 1921. Since that time, numerous synonyms have been employed, many of which utilize histological characteristics. Current consensus seems to accept "Ewing's tumor" as the most satisfactory designation for this malignant neoplasm which is recognized on the basis of histology, radiosensitivity, and prognosis.

This neoplasm constitutes approximately 10 per cent of all malignant bone tumors, being surpassed in frequency only by multiple myeloma and osteosarcoma. It most commonly occurs in young people. Ninety per cent of the cases are diagnosed prior to age 30, with a peak incidence at age 15. In infants and young children the diagnosis of metastatic neuroblastoma must be considered while in older patients undifferentiated metastatic carcinoma, lymphoma and multiple myeloma must be excluded. Of paramount importance in infants is the fact that Ewing's sarcoma may simulate osteomyelitis on both clinical and radiological grounds. Males appear to be more frequently involved than do females.

The long bones (especially the femur and tibia) and pelvis account for approximately 75 per cent of cases. The diaphysis and metaphysis are the sites of predilection while an epiphyseal origin is rarely encountered. Current consensus appears to favor a unicentric origin theory with metastases accounting for the frequently seen multiple bone involvement.

Clinically, pain, initially variable and ultimately constant, is the dominant feature. The most common physical finding is the presence of a palpable mass, frequently tender and inflammatory in appearance. Fever, leukocytosis, anemia and increased ESR are frequent laboratory findings and are thought to indicate a poor prognosis. Metastases most commonly involve the lungs and other bones but may be seen in virtually every organ.

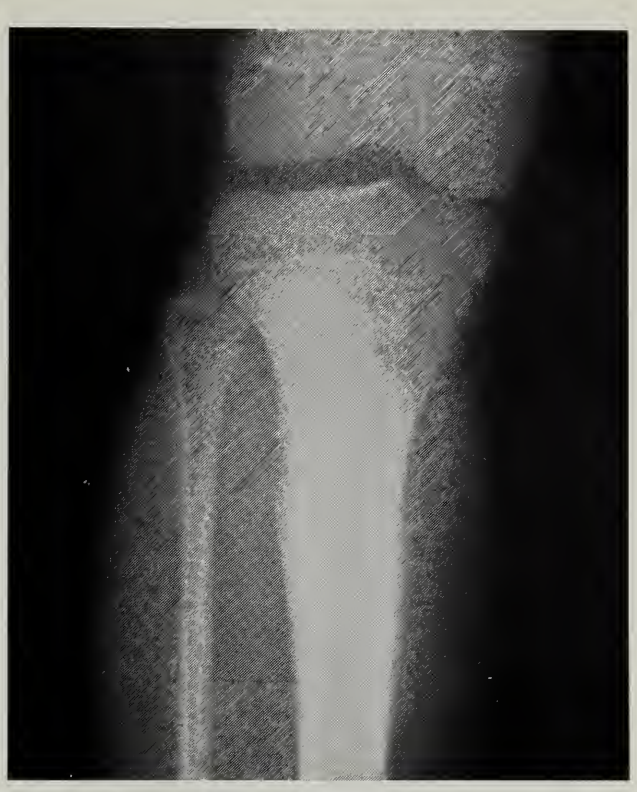
The five-year survival rate appears to be less than 5 per cent. Approximately 50 per cent die within one year and the majority within two years of diagnosis. Recurrence has been reported with some frequency as late as five years and rarely as late as 10 to 11 years.

Radiographically, there are no pathognomonic findings. Perhaps the most common and striking feature is bone destruction which may be intermingled with irregular sclerosis. The destructive changes usually originate in the medulla and ultimately involve the cortex. It is well known that the tumor invariably extends beyond radiologically recognizable limits. Periosteal elevation is frequently seen with occasional lamination ("onion peel") and Codman triangle formation. Distortion of the soft tissue planes and a soft tissue mass are frequently identified. The classic picture, exhibited in 25 per cent of cases, includes a mid-diaphyseal medullary destructive lesion with cortical erosion and laminated periosteal elevation. The diagnosis in most instances, even when radiographically typical, must await pathological confirmation.

The current treatment of choice appears to be irradiation, in view of the fact that published reports indicate essentially equal results from surgery and irradiation. The tumor is usually quite radiosensitive, and it is said that 60 per cent of primary lesions may be completely controlled with

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi School of Medicine.





Figures 1 and 2: Ewing's sarcoma of tibia in a 10-year-old female. There is mottled rarefaction with intermingled areas of sclerosis. Laminated ('onion peel') periosteal elevation is present. A soft tissue mass is not obvious. Both projections are of the same area using different radiographic techniques.

irradiation. The recommended dose to the primary bone lesion is 4000 to 6000r in four to six weeks with supervoltage therapy. Metastases, including lung lesions, may initially regress completely with radiotherapy, but in spite of this fact, death usually occurs from widespread metastases. ★★★

2500 North State St. (39216)

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THE NIGHT BEFORE MAYHEM

The irate wife was preparing breakfast when her husband came into the kitchen.

"John," she complained, "you were saying some very nasty things about me in your sleep last night."

"Who was sleeping?"

Cardiopulmonary Resuscitation

WALTER H. ROSE, M.D.
Indianola, Mississippi

Success in cardiopulmonary resuscitation depends on many factors, but the most important is the adequate training of the participants. The author discusses the history of CPR and reports on the Mississippi Heart Association's efforts to disseminate a standardized method.

THE MISSISSIPPI HEART ASSOCIATION is undertaking what it believes to be its single, most important project—the dissemination of a standardized method for performing cardiopulmonary resuscitation. Cardiopulmonary resuscitation, or CPR, was put on a sound physiological basis in 1960, by Kouwenhover, Jude and Knickerbacke[1, 2] of Johns Hopkins Medical School when they developed a simple, effective method of cardiac massage utilizing only the physicians' hands and the patient's body.

Cardiac arrest has fascinated the medical profession at least since 1848 when Hannah Green stopped breathing while a toenail was being removed under chloroform anesthesia. Many scientists have reported on this subject since that time. Some of the more notable contributions are those of

—Maas, who in 1890 successfully resuscitated a child and a young adult from cardiac arrest under anesthesia by employing closed chest cardiac compression,

—Igelsrud, who in 1901 successfully resuscitated by open chest cardiac massage a 40-year-old woman who was undergoing a hysterectomy,

—George Crile, Sr., who introduced in 1904 epinephrine for intravenous and intracardiac use,

—Claude Beck, who successfully, in 1947, internally defibrillated the heart of a young boy,

—Paul Zoll, who successfully defibrillated the human heart by external counter shock,

—James Elam and Peter Safar, who provided the big breakthrough in 1954 when they placed mouth-to-mouth ventilation on a sound physiological basis and the older methods were discarded.

Jude and associates in 1960 put these previous experiences together, leading to a profound change in the prognosis of cardiac arrest. Their method was rapidly adopted by medical schools all over the country and cardiac teams became skilled in this new method of restoring life from sudden death causes and stories of this lifesaving technique made headlines across the country. This at first alarmed many medical groups and prompted an editorial in *Circulation* in 1962,[3] that stressed that this was strictly a medical procedure and not to spread outside the profession.

Sufficient experience was accumulated during the next few years so that by 1965 another editorial appeared in *Circulation*[4] and reclassified CPR as an emergency procedure. The editorial stated: "External cardiac resuscitation is a proved and accepted lifesaving technique and should be applied as an emergency procedure by properly trained individuals of the medical, dental, nursing, and allied professions and of rescue squads."

The American Heart Association responded to this challenge and developed a sound, standardized teaching program that is being taught in all 50 states. This involves not only courses but instructor kits which include slides, movies, and training manikins. The program in Mississippi got underway in December 1966, when the first course was given by Dr. Leonard W. Fabian and Dr. Hilary H. Timmis at the University Medical Center. Ma-

Read before the 88th Semi-annual Meeting, Delta Medical Society, Cleveland, Miss., Oct. 11, 1967.

terial is available through the Mississippi State Heart Association for teaching medical, nursing and other paramedical personnel as well as rescue groups and ambulance personnel.

Briefly, the accepted technique of CPR is divided into two phases: (1) emergency measures and (2) definitive therapy.

In order for emergency measures to be taken by medical or paramedical personnel in the short lapse of time between clinical and biological death (4-6 minutes) the problem must first be recognized. It is easy for those in the medical profession to determine apnea, dilated pupils and absence of circulation, but it is difficult for non-medical personnel.

Expired air ventilation is the most efficient type of artificial respiration available today. This is quite simply done by clearing the airway of debris and tilting the head as far back as possible and at the same time lifting the neck. This dislodges the tongue and mandible from the hypopharynx and opens the airpassage. Then expired air ventilation can be carried out by mouth-to-mouth, mouth-to-nose, or mouth-to-airway methods. An AMBU bag is also quite successful and certainly more esthetic. This should be done 10-12 times per minute, 20 times per minute for small children.

Mouth-to-mouth breathing can be performed satisfactorily by first aides following minimal training but closed chest cardiac massage requires diligent training and periodic re-training of medical and paramedical personnel. (The Ressu-Annie manikin is provided for this specific purpose.)

Jude and his associates showed that external compression of the heart against the spine will produce a cardiac output sufficient to sustain life. Briefly, here are the steps in this technique: The patient is placed on a firm surface and the heel of one hand is placed over the lower end of the sternum and the other hand on top of the first and the sternum compressed 4-5 cm. toward the spine and rapidly released. This is performed 60 times per minute (80-100 for children), letting your body and back weight do the work. One hand for a child and one finger for a newborn will suffice.

LUNG INFLATION INTERPOSED

Lung inflation should be interposed between every five chest compressions. These two procedures can be carried out by a single operator or two rescuers working together. (When there is only one rescuer, the lungs should be inflated two times after each fifteen chest compressions.)

Definitive therapy refers to the physician's role in CPR. He has to decide if CPR should be initiated and continued, this depending on the inciting disease or cause of sudden death and the feasibility of returning the patient to a functional existence. It is naturally not indicated in the presence of terminal or malignant diseases. Several specific procedures have to be carried out.

RESPIRATION, CIRCULATION SUPPORT

1. The physician must continue to support respiration and circulation. Intubation of the trachea and anesthesia support are paramount. (Pressure cycled respirators are inefficient as they are tripped by cardac compression.) The physical effort required to perform closed heart compression is appreciated only by those who have had to do this for any length of time. Recently, U. S. Medical Control has marketed the Rentsch Cardiac Press and Uniflex the heart-lung resuscitator which is programmed to cycle 60 compressors a minute and interpose controlled ventilation every fifth compression. (It is demonstrated in the movie "Prescription for Life" and is available through the heart association.)

2. The physician must determine the status of the myocardium as soon as possible if initial efforts fail to restore normal circulation. The electrical status of the myocardium can be classified into three types: asystole, profound cardiovascular collapse, and ventricular fibrillation. For the first two, the administration of cardiotonic drugs, such as epinephrine, ephedrine, metaraminol, and levarterenol may help to restore cardiopulmonary function. These can be given through the intravenous or intracardiac routes because cardiac compression will circulate these drugs.

Metabolic acidosis occurs rapidly in the presence of profound cardiovascular collapse and sodium bicarbonate in a dose of 44.6 mEq. (3.75 gm.) should be administered every 10 minutes. Also calcium chloride in a dose of 0.5 gm. at five minute intervals may strengthen contractions. In the presence of ventricular fibrillation, electrical countershock is required. Both direct and alternating current defibrillators are equally successful in converting this arrhythmia. Occasionally quinidine or procaine amide in doses of 100 mg. may decrease myocardial irritability and make a second attempt successful. It is important to always continue heart-lung resuscitation without interruption during the administering of drugs and between defibrillation.

3. Post-resuscitative care requires the support of blood pressure, support of ventilation, prevention of cerebral edema (hypothemia or intravenous urea) and the treating of the primary disease.

The decision to stop CPR is a medical one and depends upon an assessment of cerebral and cardiovascular status. Deep unconsciousness, apnea, and fixed, dilated pupils for 15-30 minutes are indicative of cerebral death, and further efforts are futile. Cardiac death may be assured when there is no return of the electrocardiographic activity after one hour of continuous cardiopulmonary support. ★★★

112 East Baker St. (38751)

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2. Jude, J. R., and Elam, O.: Fundamentals of Cardiopulmonary Resuscitation, Philadelphia, F. A. Davis Company, 1965.
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IN PROPER SPIRITS

The young missionary priest was required to give his bishop a monthly accounting of all expenses and to cite an authority from the Prayer Book for each expenditure. When the young cleric turned in a voucher for two fifths of bourbon, the bishop immediately wrote:

"Where in the Prayer Book can you possibly find authority for such an expense item?"

The priest was not at a loss when he referred to the epistle for Sexagesima where St. Paul said, "Once I was stoned."

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 16-20, 1968, San Francisco, Calif.; Clinical Convention, Dec. 1-4, 1968, Miami Beach, Fla. F. J. L. Blasingame, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

American Academy of General Practice, Annual Meeting, Sept. 13-20, 1968, Las Vegas, Nev. Mr. Mac F. Cahal, Executive Director, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

Southern Medical Association, Annual Meeting, Nov. 18-21, 1968, New Orleans, La. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 100th Annual Session, May 13-16, 1968, Jackson. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. S. E. Field, Jr., Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. William O. Barnett, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 668, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday Quarterly, Jefferson Davis Memorial Hospital, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Second Wednesday March, June, September, and December. Herbert R. Power, Vaiden Clinic, Vaiden, P.O. Box 85.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, M. Beckett Howorth, Jr., 2200 S. Lamar Blvd., Oxford, Secretary.

Pearl River County Medical Society, Second Monday every month. J. M. Howell, 215 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, P.O. Box 1230, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, 1513 Clay Street, Vicksburg, Secretary.



The President Speaking

'One Letter This Year . . .'

TEMPLE AINSWORTH, M.D.

Jackson, Mississippi

MISSISSIPPI PHYSICIANS are being asked to tell their association what they desire in postgraduate medical education. Our Council on Medical Education has assumed the huge and difficult task of bringing the views and aspirations of physicians, a profile of their professional attainments, the direction in postgraduate training urged by the several specialty societies, and the findings of national studies into a single, clear focus for our state.

The study is important, because it will become the yardstick by which our program will be measured in terms of today and tomorrow. We will tailor the present capabilities as closely to the findings as we can, while looking ahead toward a more optimum program tomorrow. But today is the time for physicians to speak their wishes and personal estimates of their postgraduate medical education needs.

Recently, members of the association received a one-page questionnaire on this study. Many have already returned the survey form with thoughtful and helpful responses. For those who have not already done so, accept this personal request to take about five minutes to check off a reply. As the council chairman, Dr. William O. Barnett of Jackson, has said, the study will be no better than the advice his group is able to secure from the membership.

The survey portion of the study is the fulcrum upon which the report will be balanced. The carefully prepared and pre-tested questionnaire is much more than a ballot; it offers a means for every respondent to say in detail what he wishes. And even further along in the representative process, the report and recommendations will be placed before the House of Delegates for final decision. If you answered only one letter this year from your state medical association, this would be the most important. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
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Volume IX, Number 3
March 1968

EDITORIALS

Medical Care Costs: The Other Side of the Coin

I

The President of the United States has attacked the cost of medical care on two occasions during the young year of 1968. Even for a man who has done more to put government in the medical care financing business than all of his 35 predecessors together, this has got to be some sort of a record. It is, at least, inconsistent with Mr. Johnson's health care programs, and at the other end of the spectrum, it is an irrational, wrong-side-out interpretation of medical socioeconomics.

In his prime-time State of the Union address, the President said that "hospital and medical costs are high, and they are rising." He went so far as to say that these are among the "absolutely intolerable" conditions facing the nation. In his more recent economic message to the Congress, Mr. Johnson said that "last year, medical care prices rose 7 per cent, more than twice as fast as other prices. I shall propose new measures to slow down the spiraling cost of health care."

It is perfectly true that all but one component of health care costs have increased over the 1957-1959 economic baseline quite measurably. But to dismiss this logical and necessary aspect of the health care picture as a lot of institutions and individuals shoveling in the money is sheer nonsense. The cost of illness and injury cannot be pleasant, but neither is the asking price of a new automobile, a pushcart of groceries, or a new pair of shoes. There are, on the one hand, the cold statistics which can easily be misread and misrepresented and on the other hand, the hard reasons why the economy of health care behaves as it does. Together, they make good sense.

II

Americans spent more than $30 billion on the care of their health in 1966, the last year for which complete and reliable data are available. The rate of expenditure is increasing as much as 5 to 7 per cent annually, but a rate of expenditure does not necessarily reflect a cost increase. It is basic and fundamental that when more individuals purchase more goods and services in a market of progressively increasing supply, the amount spent will increase, even with totally static cost levels.

Before anyone paints the health care picture black, they ought to examine what Americans have to spend and how they choose to spend it. The economists call this ready cash "disposable personal income," a neat way of saying what's left after the tax bite. We Americans had over $509 billion in 1966, and we spent 6 per cent of it, about $30 billion, on our health. Over a fifth of our money goes for food, while housing and household operation claim a third. Nearly 13 per cent is spent for transportation, and a tenth is spent for clothing.

And let it be noted in passing that we spend twice as much for tobacco and haircuts as we do for education, and the liquor bill is triple our church and religious gifts.

Twenty years ago, say the critics of health costs levels, we were spending only 4 per cent of our disposable personal income on health care. But this argument doesn't jell quite as well when hard money comes into the picture. In 1948, all Americans had only $190 billion to spend against $509 a score of years later. Of greater importance, they had much more purchase opportunity in the health care field in 1966 than 20 years previously.

III

Government has been, far and away, the greatest force in accelerating health care expenditures. Medicare is looking at a $6.3 billion budget for 1968-1969, and nobody really knows what the sum total of the Title XIX programs will cost in this period. The OEO's poverty war might have suffered a cut at the hands of the Congress, but its health program actually received a 25 per cent increase.

Government-supported research funds have been increased, and federal aid to medical education, often spilling over into the care picture, is up as never before. There are dozens of project and formula grants for care under the U. S. Public Health Service. This isn't to bring a discussion of merit or undesirability; it's just to point out that the money is there and that is does get into the health care pipeline.

And some may find it confusing that the same President of the United States who pushed federal minimum wage also stands before the body which enacted it and jumps on the cost of hospital care. The second round of mandatory wage increases under the law largely accounts for the fact that hospital costs went up 14.3 per cent last year over 1966 to a record high of $56 per day. Every indicator points to a 15 per cent boost this year, too.

But on the consumer price index, the cost of physicians' services closely parallels the general increase in what we pay for all goods and services. Since 1957-1959 when the present CPI is calculated at 100, the cost of all goods and services today is 113.1, and physicians' fees are listed at 128.5 for the same period. But professional fees lagged the economy in the postwar decade and were slow in rising while other costs shot up. In the distribution of the health care dollar, the physician got 27 cents in 1966 against 28 cents in 1956, but the hospital's share went from 25 cents in 1956 to 32 cents in 1966. This, then, is the other side of the cost coin.

IV

The economic phenomenon of the 20th century, private and voluntary health care financing, is still the greatest single factor in the astonishing ability of Americans to purchase the best and most complete health care services in the world. In fact, it seems a little incongruous to pretend that every health care dollar is spent out-of-pocket when it is not. Some argue with forceful logic that insurance and voluntary prepayment insurance ought to be deducted from the cost side of the equation or else added to the disposable personal income total. The fact is that the money is there for health care, and that's the only way it may be spent.

In 1966, we Americans paid $12.7 billion for health insurance and voluntary prepayment coverage. In that year, we received $5.6 billion from insurance carriers and $4.6 billion from Blue plans and medical society-sponsored programs.

A whopping 82 per cent of all citizens, some 163 million, have hospital coverage. About 148 million have surgical benefits, and 115 million carry regular medical protection. A smaller yet growing group of just under 60 million carry major medical contracts. Of these cost-protected Americans, half of the over 65 group are included, giving them protection over Medicare.

V

If the critics of health care costs were as willing to come reason together with the facts as they are to attack the statistics, there would be greater understanding about this complex matter. Nobody, least of all a state medical association, is attempting to assert that good, quality health care in the



"We all agree, but will the patient accept the diagnosis of jungle rot?"

late 1960's is cheap in terms of today's price levels. It cannot be and still embody the quality and extent of services which the ill and injured must have. Nor can the human cost factor be minimized, when, for example, almost 70 cents out of every dollar a hospital receives must go for salaries and wages.

This is to say that the cost of health services in the United States is structured on rational bases, relevant to the times, the demand, the capability of the delivery system, and the capacity of consumers to purchase it or have it purchased for them. It will become more expensive, especially as regards hospitals, extended care facilities, and any institutional services.

There is an old axiom that health care costs are sometimes resented because such expenditures are usually something which cannot be planned, they purchase something which is unwanted in the first place, and they can deny the purchaser a more pleasurable expenditure. After all, who wouldn't rather buy a new outboard motor than have his gallbladder taken out? But there are two sides to the coin which purchases the productive, ever-increasing human life span, and the fair minded fellow will look at both.—R.B.K.

Quackery at the End of the Rainbow

American medicine has roundly denounced the "rainbow pill regimen" for obesity, warning that weight reduction is a leading health area for quackery. A new surge of interest has followed an investigation by the Senate Subcommittee on Antitrust and Monopoly, feature articles by popular magazines, and statements by the American Medical Association.

The Senate hearing produced testimony that some physicians and osteopaths have apparently shifted their practice emphasis to obesity control, giving their patients handsful of barbiturates, thyroid extracts, amphetamines, thiazines, diuretics, laxatives, and hormones.

Public health officials in Illinois and Oregon testified that such pills have been associated in at least 20 deaths. Witnesses for AMA at the hearings, Dr. Theodore B. Van Itallie of New York and Dr. Harry C. Shirkey of Birmingham, told the senators that "the obese are extremely gullible, forever willing to believe that someday a gadget, a diet, a pill, or a book will lead to the miracle of easy and painless reduction of weight.

"While most of the quackery originates with health hucksters who have no scientific background, training, or qualifications in the medical or nutritional fields," Drs. Van Itallie and Shirkey said, "unfortunately a physician is occasionally involved."

The AMA takes the position that a physician who assumes the responsibility for treating obesity takes on a difficult role. Few medical disorders require the same disciplined and prolonged cooperation of a patient, and even under the most ideal of circumstances, the results of the treatment become apparent slowly.

Dr. Shirkey places the rainbow pills into these classifications and comments on each:

Cardiac glycosides: "Their use for obesity is reprehensible and may well have attributed to the few reported deaths of patients receiving such treatment."

Hormones—thyroid: "There are at least three irrationalities in this hormonal approach to the treatment of obesity."

Diuretics: "There is no rational basis for the use of diuretic drugs in the treatment of simple obesity."

Anorexiants: "Amphetamines are useful as a crutch to help the patient become accustomed to a rigorous reducing diet. But long-term administration is not justified, because they tend to become less effective and, in addition, can lead ultimately to habituation."

Laxatives: "There is little rational basis for the use of laxatives in the treatment of obesity."

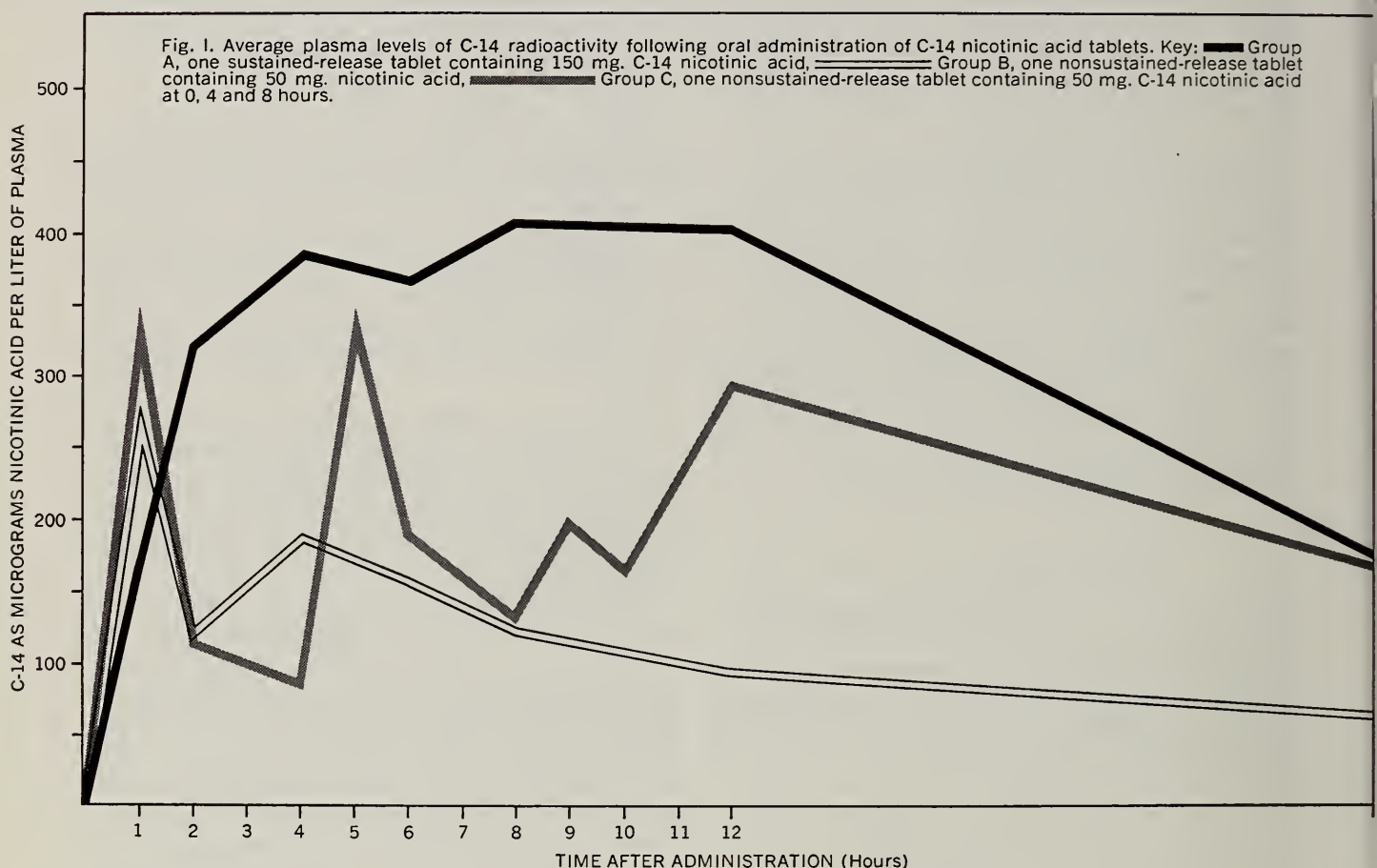
Perhaps the rainbow pill fad is another chapter in the succession of calories-don't-count, safflower oil capsules, the drinking man's diet, and other ineffective and possibly dangerous nostrums. But the warning of AMA is timely, and there can be no doubt that the Congress and agencies of government are deadly serious about bringing it to a halt.—R.B.K.

These Eggs Go in the Same Basket

This is a true story which happened in the District of Columbia, and it could happen tomorrow to any physician in Mississippi. A patient, crippled by poliomyelitis, came to a physician's office. After having been helped from a wheel chair to a stool, the patient fell while the doctor stood an arm's length away waiting for his nurse. Sustaining injury, the patient sued.

The unfortunate physician carried his professional liability insurance with one company and his premises liability (OL&T) with another car-

Sustained circulatory, respirato
and cerebral stimulation for th





(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

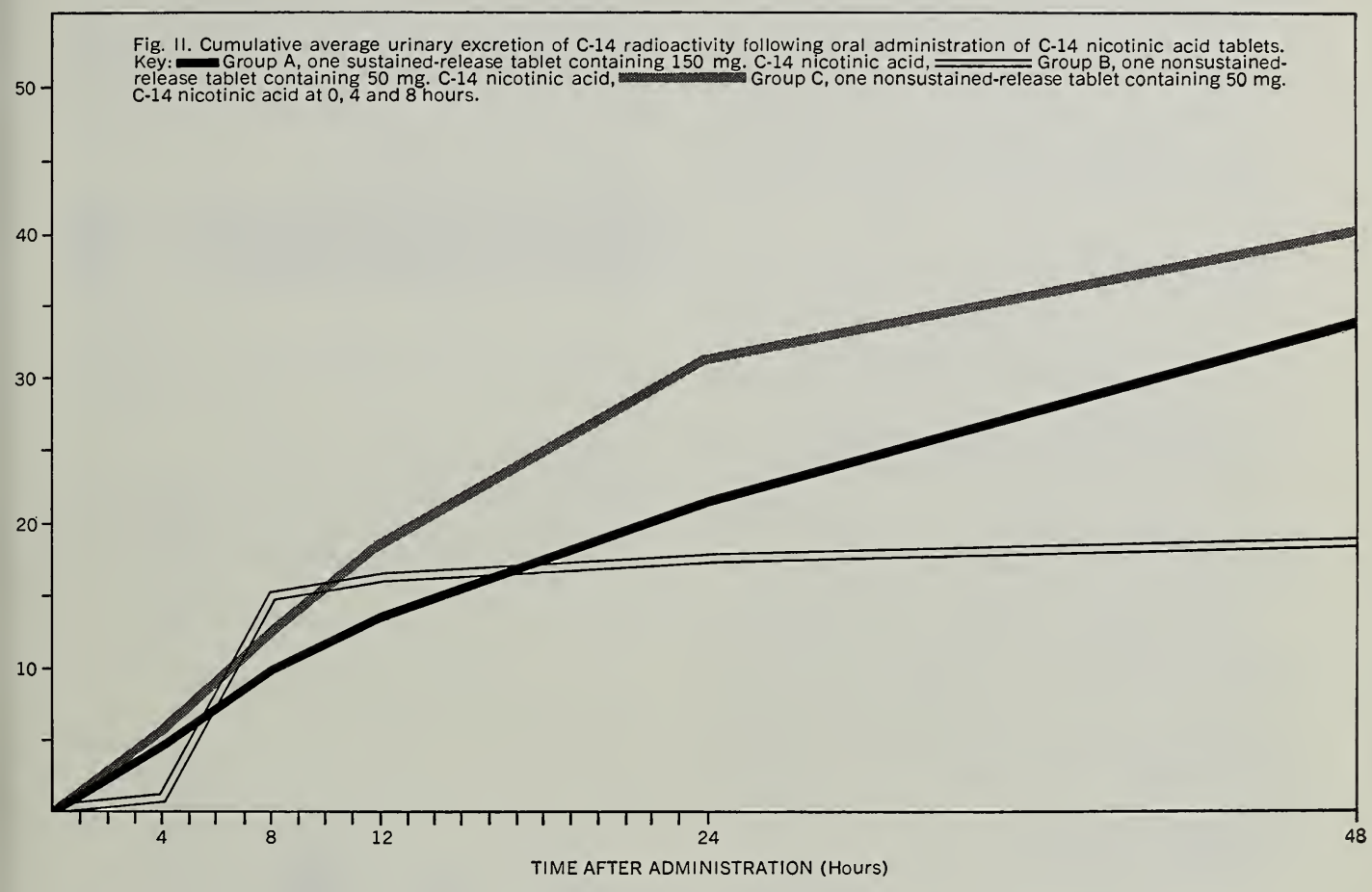


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ess confused and moody. Personal care, memory, motional stability, social attention improve. Fatigue, pathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, t an economical price. Dosage is only one tablet every 2 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

rier. Each denied liability in the suit. The professional liability company pointed out that no care had been undertaken and that the patient's injury could not possibly have been the result of professional negligence or malpractice.

The premises liability carrier contended that it had no obligation, since the terms of its policy clearly stated by specific exclusion that there could be no liability for injury, sickness, disease, death, or destruction due to the rendering of or failure to render any professional service. And after all, the patient was in the office to see the doctor.

In a distasteful, four-way suit, the harried physician was finally defended, but his extra expense, anxiety, and uncertainty netted him a substantial loss. In the case with the impressive citation, *Hazard v. Aetna Casualty and Surety Co. and Third Party Plaintiff v. United States Fidelity and Guaranty Co., Third Party Defendant, U. S. Dist., D. C., 1567-65, April 28, 1966, 12 CCH F. and C., 1048,* the doctor learned that these two insurance eggs should be carried in the same basket. The court said that a gray area exists in cases such as these between the two types of insurance where an accident may be seen as the result of either ordinary negligence of a property owner or of a failure in the rendering of professional services.

There is ample evidence in this and similar cases that a gray area does exist vís-a-vís OL&T liability and professional liability insurance. The conclusion is clear: Both contracts should be carried with the same company, and the OL&T should logically be written by the professional liability carrier, since the latter form is more stringently underwritten.

And the experts with real insurance savvy counsel still another important consideration. The limits of liability for each policy should be the same—just in case the single carrier decides to categorize the accident under the lesser-limits contract when one provides more protection than the other.

These are pretty important eggs, and it's worth the time it takes to check which basket they are in today.—R.B.K.

Aesculapian Hawks and Doves

Most folks are getting weary of the ornithological labels of hawks and doves as relate to a viewpoint on the participation of the United States in Vietnam. But if it gets down to a matter of putting wings and feathers on American physicians, a substantial majority will have meat-tearing beaks and sharp talons. In a word, they are hawks.

Marion Laboratories of Kansas City instituted an interesting physician-opinion program last year called "Playback." Each month, 10,000 physicians received a summary of major news events recorded by the National Broadcasting Co. on a long-play record. Along with the album is an opinion poll questionnaire which the recipient physician is asked to complete and return after hearing the record. The questionnaires are processed by computer and analyzed by a nationally-known opinion research organization.

The January poll on Vietnam showed that seven out of 10 American physicians are opposed to the U. S. getting out of the war with only 21 per cent feeling that we should and a mere 8 per cent undecided. Regionally, those saying stay and fight ranged from a low of 68 per cent in the East up through 70 per cent in the West and 72 per cent in the Midwest to the most hawkish of all, the Southerners, who polled 73 per cent.

Physicians urging withdrawal of U. S. forces from Vietnam make up one out of four doctors in the East but dwindle down to a trickle of 16 per cent in the South. Nearly seven out of 10 felt



"My, what rosy cheeks you have!"

that the loss of Vietnam by the United States would result in more Red Chinese aggression.

When the question, "Do you think the Vietnam protesters provide a useful service?" was asked, the computer must have blown a fuse, because the overwhelming response was "no!" This ranged from a substantial 66 per cent in the West up to the deluge majority of 81 per cent in the South.

This is not, of course, to urge any particular view upon anybody, but inasmuch as physicians, wherever they are, constitute a strong force in the shaping of public opinion, these findings ought to discourage potential Vietnik demonstrations south of the Mason-Dixon.—R.B.K.

POSTGRADUATE CALENDAR

CARE OF THE TERMINALLY ILL

March 14-15

This seminar on religion and medicine is sponsored by the University of Mississippi School of Medicine; the Department of Medicine and Religion, American Medical Association; the Committee on Medicine and Religion, Mississippi State Medical Association, in cooperation with the Mississippi Academy of General Practice.

Lecturers will be the Rev. Paul B. McCleave, director of the American Medical Association Department of Medicine and Religion, Chicago, Ill.; Dr. Paul B. Brand, chief of rehabilitation services, U.S.P.H.S. Hospital, Carville, La., and the Rev. Van Arnold, pastor of Evergreen Presbyterian Church, Memphis, Tenn.

ADVANCES IN DIAGNOSIS AND MANAGEMENT OF CANCER

During the current academic year, The University of Mississippi Medical Center will offer a weekly program on various aspects of cancer diagnosis and management, under the auspices of the Tumor Clinic Committee with the aid of a United States Public Health Service Clinical Cancer Training Grant.

The series, held on successive Tuesdays throughout the year, is open without fee to all physicians. Meetings are in Room 3A of the University Medical Center from 5:00 p.m.-6:00 p.m. Coffee will be served.

Tuesday, March 12

Bladder Carcinoma
Dr. W. L. Weems, Assistant Professor of Surgery and Dr. B. T. Hickman, Associate Professor of Radiology

Tuesday, March 19

Testicular Tumors
Dr. Jack Aldridge, Surgery Resident and Dr. B. T. Hickman, Associate Professor of Radiology

Tuesday, March 26

Carcinoma of the Kidney
Dr. Meredith Bradford, Surgery Resident

15TH ANNUAL CARDIOVASCULAR SEMINAR

University Medical Center, Jackson
March 27, 28, 29, 1968, beginning at 8:30 a.m.

Sponsored by the University Medical Center and the Mississippi Heart Association.

Participants

George E. Burch, M.D., Professor of Medicine and Chairman of the Department, Tulane University School of Medicine, New Orleans
J. Scott Butterworth, M.D., Associate Professor of Medicine, New York University School of Medicine, New York City
Caesar A. Caceres, M.D., Heart Disease Control Program, Instrumentation Field Station, Washington, D. C.
Alvan R. Feinstein, M.D., Associate Professor of Medicine, Yale University School of Medicine, New Haven
Gerald L. Schiebler, M.D., Associate Professor of Pediatrics, University of Florida College of Medicine, Gainesville
Hilary H. Timmis, M.D., Associate Professor of Surgery, University Medical Center

Wednesday, March 27

Endocardial Fibroelastosis
Dr. Schiebler
Limited Factors of Cardiac Ausculation and How to Overcome Them
Dr. Butterworth
Cardiac Surgery in the Newborn
Dr. Timmis
Pediatric Grand Rounds

Recess for Lunch

POSTGRADUATE / Continued

Electronics, Computers and Communications in Clinical Medicine
Dr. Caceres
Roentgen Approach to Congenital Heart Disease: I. Left-to-Right Shunt Lesions and Endocardial Fibroelastosis
Dr. Schiebler

Thursday, March 28

Acoustic Distinctions in Cardiac Auscultations
Dr. Feinstein
Office and Bedside Diagnosis of Cardiovascular Disease
Dr. Butterworth
Automated Screening Procedures as an Aid to the Practitioner
Dr. Caceres
Surgery Grand Rounds: Principles and Progress in Heart Replacement

Recess for Lunch

Roentgen Approach to Congenital Heart Disease: II. Obstructive Lesions and Cyanotic Malformations
Dr. Schiebler
Problems in Evaluating Cardiovascular Therapy
Dr. Feinstein

Friday, March 29

Clinical Vectocardiography
Dr. Burch
Electrocardiography and Its Future in the Era of Computers
Dr. Caceres
Why Statistics May Lie About Cardiac Disease
Dr. Feinstein
Medicine Grand Rounds

Center Assembly, Lunch

Interpretation of the Electrocardiogram Following Physical Exercise Stressing
Dr. Butterworth
Management of Myocardial Infarction
Dr. Burch

CIRCUIT COURSE

East Central Circuit
Meridian—April 2, Northwood Country Club, 6:30 p.m.
Session 2—Diagnosis and Management of Anemia
In Adults, Dr. Guy Gillespie
In Children, Dr. Robert Carter

FUTURE CALENDAR

March 1

Symposium on Renal Disease

March 5

Circuit Course, Meridian

March 14-15

Care of the Terminally Ill

March 27-29

Cardiovascular Seminar

April 1-2

American Board of Surgery

April 2

Circuit Course, Meridian

April 11

Diabetes Seminar

April 16

Circuit Course, Natchez

April 18

Thoracic Society

April 23

Circuit Course, Columbus

May 7

Circuit Course, Meridian

May 13-16

Mississippi State Medical Association

PERSONALS

Nino A. Bologna of Greenville has been elected president of the Greenville Park Commission. He has served as a commission member for eight years.

R. H. Bostwick of New Albany has been appointed to the Board of Trustees of the Union County Hospital. The appointment was made by the county board of supervisors, and Dr. Bost-

wick will represent the Third District of the county on the five-member governing body.

JOE S. COVINGTON of Meridian and JAMES O. MANNING of Jackson have been elected to the Board of Directors of the Mississippi Chapter of the Arthritis Foundation. Dr. Covington limits his practice to internal medicine, and Dr. Manning, to orthopaedic surgery.

JOHN A. CRAWFORD of Louisville has been awarded a citation for 25 years of volunteer, uncompensated service to the Selective Service Board No. 86 as medical adviser. The certificate of citation and lapel button were presented during special ceremonies by Col. James L. Davis, state director of the Selective Service System.

JOHN P. ELLIOTT, JR., of Tupelo has announced the association of JAMES O. GORDON at 605 Garfield St. Drs. Elliott and Gordon limit their practice to urology.

GEORGE E. GILLESPIE of Jackson has been elected financial chairman of the Little Red Schoolhouse, a community service organization for retarded children.

WILLIAM M. GILLESPIE, JR., of Meridian has been elected chief of staff of the Jeff Anderson Memorial Hospital for 1968. Other Meridian physicians elected officers of the staff include DANIEL R. THORNTON, vice chief of staff; RAY STODDARD, secretary; WILLIAM J. ANDERSON, JR., chief of surgery; WILLIAM L. CARTER, JR., chief of medicine; JOHN E. LINDLEY, chief of obstetrics and gynecology; and C. L. GASTON, JR., member of the executive committee.

PAUL E. GOODE of Jackson has been elected first vice president of the recently chartered Jackson Suburban Lions Club. The new club was activated in special ceremonies by Lions International and the new officers formally installed.

FRANK G. GRUICH and WARREN C. PLAUCHE of Biloxi formally opened their new clinic building at 1127 W. Division St. recently. The 2,800 square feet of space furnishes 18 rooms, including five examining rooms, three consulting offices, expanded laboratory, library, and reception facilities.

CLYDE H. GUNN, JR., of Moss Point has been elected a member of the Board of Directors of the First Federal Savings and Loan Association of Pascagoula and Moss Point.

JAMES E. HARRIS of Hattiesburg has announced the temporary removal of his offices to Suite 123 of the Humble Building. After July 1, Dr. Harris anticipates being located in the New Medical

Q. How much does the **anticostive* hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
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Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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490-7—6064

Plaza near Forrest General Hospital. He limits his practice to otology, laryngology, and maxillofacial surgery.

MARTIN B. HARTHCOCK, JR., of Jackson has been elected to the Board of Directors of the Capital City Kiwanis Club.

LEROY HOWELL of Starkville has been elected president of the medical staff of the Felix Long Memorial Hospital for 1968. Other Starkville physicians named as officers of the staff are JOHN C. LONGEST, vice president, and KERMIT D. LAIRD, secretary.

JOHN D. MCEACHIN of Meridian has been nominated for the 1967 Jaycee Distinguished Service Award. He was cited for outstanding service in the Meridian Chamber of Commerce, as a director of the Meridian Symphony Orchestra, and for activities of service in the Lauderdale County Tuberculosis Association and the Millsaps College Alumni Association.

TOM H. MITCHELL of Vicksburg will leave the United States this month for a two months tour of duty in South Vietnam under the AMA Volunteer Physicians for Vietnam program. The program is financed by the U. S. Agency for International Development and administered by AMA. Physician volunteers work in provincial civilian hospitals.

J. R. MULLENS of West Point will soon occupy his new clinic building on East Street.

J. ELMER NIX and WILLIAM B. THOMPSON of Jackson have been inducted as Fellows of the American Academy of Orthopaedic Surgery during the 35th Annual Meeting of the specialty group at Chicago. Fellowship in AAOS is dependent upon the candidate's having been certified by the American Board of Orthopaedic Surgery.

CHARLES PRUITT, JR., of Magee and NORMAN W. TODD of Newton are serving on the 15-member state executive committee of the Mississippi Republican Party.

L. VAUGHN RUSH, JR., of Meridian has been nominated for the 1967 Jaycee Distinguished Service Award. He was cited for outstanding community service in many areas of endeavor.

GUY T. VISE of Meridian has been cited for 25 years of volunteer, uncompensated service to the Selective Service System in Mississippi. In special ceremonies, Dr. Vise received a certificate and lapel pin in recognition of his work. He is a past president of both the Mississippi State Medical and Southern Medical associations.



Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy. Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



ROHRER WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association:

CARTER, ROBERT ELDRED, Jackson. Born Minneapolis, Minn., June 14, 1923; M.D., University of Minnesota Medical School, Minneapolis, 1948; interned Cleveland City Hospital, Cleveland, Ohio, one year; pediatrics residency, University of Chicago Clinics, Ill., two years; fellow, American Academy of Pediatrics; diplomate of the American Board of Pediatrics; Director and Dean of the University of Mississippi School of Medicine; elected Dec. 2, 1967, by Central Medical Society.

CORBAN, MAGRUDER SULLIVAN, Gulfport. Born Biloxi, Miss., September 26, 1932; M.D., Tulane University School of Medicine, New Orleans, La., 1957; interned Charity Hospital, New Orleans, one year; orthopaedic surgery fellowship, Tulane University School of Medicine, New Orleans, one year; elected July 12, 1967, by Coast Counties Medical Society.

ERVIN, ROBERT NORMAN, Gulfport. Born Hazelhurst, Miss., June 25, 1931; M.D., University of Tennessee College of Medicine, Memphis, 1956; interned Mobile General Hospital, Mobile, Ala., one year; radiology residency, one year and neurological surgery residency, five years, Los Angeles General Hospital, Los Angeles, Calif.; general surgery residency, Lloyd-Noland Hospital, Fairfield, Ala., one year; member, American Academy of Neurological Surgery; elected July 12, 1967, by Coast Counties Medical Society.

GARBIN, FRANK GEORGE, Ocean Springs. Born Biloxi, Miss., March 10, 1929; M.D., University of Tennessee, College of Medicine, Memphis, 1955; interned St. Joseph Hospital, Memphis, Tenn., one year; general surgery residency, San Juan City Hospital, San Juan, P. R., four years; elected Nov. 8, 1967, by Coast Counties Medical Society.

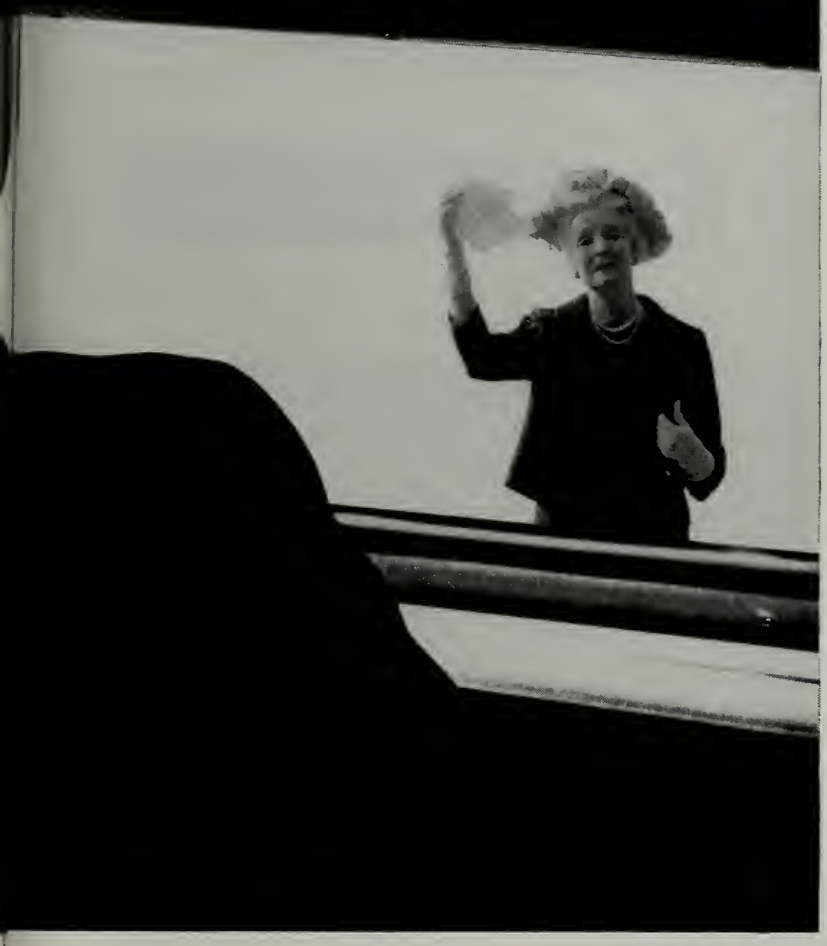
GIBSON, LEO EIKE, JR., Picayune. Born Lynchburg, Va., July 15, 1935; M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1961; interned University of Mississippi Medical Center, Jackson, one year; ob-gyn residency, University of Mississippi Medical Center, Jackson, three years; elected Jan. 10, 1968, by Pearl River County Medical Society.





Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (includ-

When a milestone in life is marred by depression...



Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by such symptoms of depression as feelings of sadness, incapacity, helplessness and hopelessness.

In about 3 out of 4 cases, Tofrānil relieves symptoms of primary depression.

As maintenance therapy in primary depressive illness, it helps prevent relapse.

Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

Tofrānil® imipramine hydrochloride Geigy

ing hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).

Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.

A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.

Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.

(B)46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

NEW MEMBERS / Continued

GRONVALL, JOHN ARNOLD, Jackson. Born Minneapolis, Minn., July 28, 1931; M.D., University of Minnesota Medical School, Minneapolis, 1956; interned Minneapolis General Hospital, Minn., one year; pathology residency, University of Minnesota Medical School, three years; elected Jan. 2, 1968, by Central Medical Society.

HAWKINS, MARY ELIZABETH, Jackson. Born New Orleans, La., July 6, 1936; M.D., Louisiana State University School of Medicine, New Orleans, 1963; interned University of Mississippi Medical Center, Jackson, one year; ob-gyn residency, University of Mississippi School of Medicine, Jackson, three years; elected Dec. 2, 1967, by Central Medical Society.

SMITH, ROBERT RAY, Jackson, Born Vicksburg, Miss., March 4, 1933; M.D., University of Mississippi School of Medicine, Jackson, 1961; interned Brook General Hospital, Fort Sam Houston, Texas, one year; neurological surgery residency, University of Mississippi Medical Center, Jackson, five years; elected Dec. 2, 1967, by Central Medical Society.

STAPP, WILLIAM FINKBINE, Jackson. Born Biloxi, Miss., March 20, 1920; M.D., Marquette University School of Medicine, Milwaukee, Wis., 1951; interned Parkland City-County Hospital, Dallas, Texas, one year; clinical pathology residency, Parkland Memorial Hospital, Dallas, 3 years; V.A. Hospital, McKinney, Texas, one year; John Sealey Hospital, Galveston, Texas, two years; coagulation research, University of Vienna Medical School, Vienna, Austria, 2 years; post doctorate Fellowship, cancer research, Baylor University Medical Center, Dallas, one year; Fulbright medical research fellowship, Oslo, Norway, one year; member, American Society of Clinical Pathologists; elected Jan. 2, 1968, by Central Medical Society.

LETTERS

SIRS:

The ability of physicians to maintain life for very long periods in the unconscious patient raises the question as to how long such skills should be deployed. As physicians we are eager to promote the recovery of everyone who can do so. In order to deprive no one of his chances on this score it is relevant to know the longest periods of coma which have been followed by useful survival.

A committee of the Massachusetts General Hospital is studying our own records and the world literature to determine pertinent features in all patients who, *despite coma for over five weeks,* have made a useful recovery. We think it is vital not to overlook any well documented patient in this category. We should be grateful if any reader of this JOURNAL would draw our attention to any case published under a title which is not indicative of survival after prolonged coma. We are also eager to receive accounts of such cases as yet unreported. A publication incorporating our own and others' data is planned.

WILLIAM H. SWEET, M.D., D.Sc.
CHAIRMAN, COMMITTEE ON MANAGEMENT OF THE UNCONSCIOUS PATIENT
MASSACHUSETTS GENERAL HOSPITAL
BOSTON, MASSACHUSETTS 02114

DEATHS

ROSENKRANZ, OTTO HENRY GUSTEN, Jackson. M.D., University of Pennsylvania School of Medicine, Philadelphia, 1908; Doctor of Public Health degree, University of Pennsylvania, 1920; died Jan. 23, 1968, aged 86.

WIGGINS, JAMES PURVEY, Cleveland. M.D., University of Tennessee College of Medicine, 1908; interned Vicksburg Charity Hospital, one year; Emeritus member of MSMA and member of the Fifty Year Club; died Jan. 20, 1968, aged 82.

Dr. Brooks Will Teach, Study in Asia

Dr. Thomas J. Brooks, Jr., professor of preventive medicine and chairman of the department at the University Medical Center, has received the Alan Gregg Travel Fellowship in Medical Education for 1968.

Awarded annually by the China Medical Board of New York, Inc., the fellowship will enable Doctor Brooks to spend seven months in Japan. Taiwan and Thailand where he'll study medical education, particularly the teaching of preventive medicine.

Nickel Beer Is Back at 100th Annual Session's Roaring Twenties Speakeasy

Racoon coats, tin lizzies, the Charleston, and Hudson Motors stock bought on 10 per cent margin will be high style at the association's annual party during the 100th Annual Session when the "Roaring Twenties" are relived on Wednesday evening, May 15. The Gaslight Club of Chicago, where time stands still in 1927, has agreed to lend the association its four flappers and band.

Although the Prohibition Laws require absolute discretion in announcing arrangements, Dr. Walter H. Simmons of Jackson, annual session chairman, was heard to mention that the speakeasy would be open at 7:00 p.m. at the Hotel Heidelberg in the swinging Capitol St. district of Jackson.

Those knocking at what appears to be the public library door—really the Victory Room—should tell the bouncer that "Temple sent me."

Word is also out the "nickel beer is back" with frosty steins selling for a jitney during the evening. Proceeds from suds sales will be used to pay off AMA-ERF and its medical education untouchables to keep the party quiet.

Dr. Simmons said that, barring raids, dinner will be served early in the evening before the continuous show erupts. There will be a full floor



"Oh, you kid and 23, skidoo!" It's the Gaslight Club flappers, direct from the speak in Chicago, Barbara, Nancy, Sandy, and Judy. Specialties are the Charleston and nostalgic numbers of the Roaring Twenties. Flappers and club band will present four floorshows during annual association party at 100th Annual Session.



show every hour, and the frolickers will be given noise-makers and match books right out of the Roaring Twenties.

The chairman also said that the entire evening is for fun with no speeches or other serious goings-on, except for interruptions for announcements as to breaks in the stock market and election returns to report the progress of Big Bill Thompson's machine in winning back the mayor's office in Chicago.

Dress in the style of the Twenties is optional, but advance gossip indicates flapper beads and skirts, along with sailor straw hats, blazers, and racoon coats are in strong demand. Tickets will be available under-the-counter at general registration, the chairman added.

Elections Are Set for 100th Annual Session

Component medical societies and members of the state medical association have been called on to suggest nominees for office at the 100th Annual Session. Meeting at Jackson last month, the Board of Trustees approved a proposal by the secretary-treasurer, Dr. Walter H. Simmons of Jackson, to encourage all members to consider vacancies which will occur in offices in May.

The proposal also carried the suggestion that members convey suggestions for nominations to elected delegates to the 100th Annual Session. Study will be given to revising the nomination process so that the Nominating Committee may be chosen as far as a year in advance, where local societies are invited to suggest nominees, and where such nominees must have been consulted in advance of the annual session as to their willingness and ability to serve, if elected.

At the 100th Annual Session, slated for May 13-16 at Jackson, the House of Delegates will name seven top officers, three members of the Board of Trustees, 12 members to various councils, nominees to the Board of Trustees of Mental Institutions, and nominees for the Board of Directors of the Mississippi Hospital and Medical Service, Inc.

No terms on the Mississippi State Board of Health expire in 1968, so delegates will not select nominees for the board this year.

Officers to be named include the president-elect, three vice presidents, an associate editor of the JOURNAL, a delegate to the American Medical Association, and an alternate AMA delegate.

Trustees for Districts 4, 5, and 6, the mid-state area, will be named, as will members for the coun-

cils on Budget and Finance, Medical Education, Constitution and By-Laws, Legislation, Medical Service, and Judicial Council.

In addition to the offices of president-elect and the three vice presidents, delegates will name an associate editor for the term 1968-70. Dr. George H. Martin of Vicksburg is the incumbent. A delegate and alternate delegate to AMA will be named for terms Jan. 1, 1969, through Dec. 31, 1970. Incumbents are Drs. Howard A. Nelson of Greenwood and Stanley A. Hill of Corinth, respectively.

Trustees whose terms expire include Dr. Mal S. Riddell, Jr., of Winona, District 4; Dr. John B. Howell, Jr., of Canton, District 5; and Dr. Lamar Arrington of Meridian, District 6. Drs. Howell and Arrington are ineligible for re-election under the three-term limitation rule in the By-Laws.

Single council offices up in May include those of Dr. J. T. Davis of Corinth, Council on Budget and Finance; Dr. William O. Barnett of Jackson, Council on Medical Education; and Dr. Raymond S. Martin of Jackson, Council on Constitution and By-Laws.

Three vacancies will occur on the Council on Legislation. Incumbents whose terms expire are Dr. John G. Egger of Drew, District 1; Dr. James O. Gilmore of Oxford, District 2; and Dr. Frank M. Davis of Corinth, District 3. Also with vacancies in the northern third of the state is the Judicial Council. The three members with expiring terms are Dr. E. LeRoy Wilkins of Clarksdale, District 1; Dr. R. L. Wyatt of Holly Springs, District 2; and Dr. T. N. Braddock, Jr., of West Point, District 3. Dr. Wilkins is ineligible for re-election.

Council on Medical Service vacancies will be in District 4, Dr. Paul B. Brumby of Lexington; District 5, Dr. John G. Caden of Jackson; and District 6, Dr. Guy T. Vise of Meridian. Dr. Vise is ineligible to succeed himself.

Five nominations must be made to Governor Williams for one seat on the Board of Trustees of Mental Institutions now held by Dr. Victor E. Landry of Lucedale. The four Blue Cross-Blue Shield directors whose terms will expire are Drs. S. Lamar Bailey of Kosciusko, Joseph B. Rogers of Oxford, and James Grant Thompson of Jackson. Dr. Stanley A. Hill of Corinth has been nominated to serve the unexpired term of the late Dr. M. Q. Ewing of Amory, and this seat is also on the ballot.

Scientific sections will conduct elections for officers with all groups naming new chairmen and the sections on General Practice and Eye, Ear, Nose, and Throat naming secretaries for three year terms.

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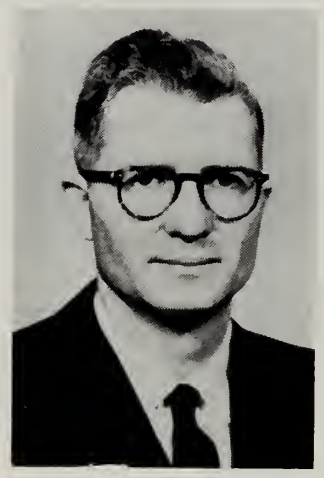
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Dr. Hardy Wins 1968 'Missy' Award

Dr. James D. Hardy of Jackson will become one of 31 citizens who shall have received the First Federal Foundation-University of Mississippi Award for outstanding achievement and distinguished service to the state. The professor and chairman of the department of surgery at the University Medical Center is the fifth physician to be honored in the history of the 10 year program.



Dr. Hardy

Other recipients for 1968 are R. E. Dumas Milner, Jackson industrialist, and Hodding Carter of Greenville, Pulitzer Prize-winning journalist.

The award series was established by First Federal of Jackson in 1958 and is conducted through the University of Mississippi. The annual presentation occasion is a highlight of the winter social season in the capital city with a select gathering of leaders in industry, government, education, and the professions.

Awardees are selected from nominations by individuals and organizations at district level and by a secret committee at state level. Previous physician awardees are Drs. David S. Pankratz, now of Memphis, former dean of UMC; Arthur C. Guyton of Jackson, professor of biophysics and physiology at UMC; W. L. Jaquith of Whitfield, distinguished director of the Mississippi State Hospital; and the late Felix J. Underwood, pioneer public health official.

Dr. Hardy has been the original and only occupant of his chair at UMC, coming to the medical center in 1955. He is a native Alabamian and received his premedical education at the University of Alabama. His M.D. degree was earned from the University of Pennsylvania, as was the Master of Science in surgery. His postgraduate training continued after service in World War II as a medical officer at Philadelphia.

He is a diplomate of both the American Board of Thoracic Surgery and American Board of Surgery. A Fellow of the American College of Surgeons, he has served as president of the Society of University Surgeons and is a member of select surgical societies. He has been a pioneer in investigative surgery, performing the first heart transplant, the first human lung transplant, the first kidney autotransplant, and the first human adrenal gland autotransplant in the United States.

The award citation states that Dr. Hardy "is a man dedicated to medical education to the advancement of medical science, and his dedication has been a positive and forceful factor in the dynamic growth of the University Medical Center during its brief existence.

"He is an Alabamian whose contributions to his adopted state are immeasurable. They reach far into the future and will affect the lives and health of generations yet unborn.

"The esteem in which Dr. Hardy is held by his colleagues is evidenced by the hundreds of invitations he has received to speak to medical groups across the nation and around the world."

Dr. Porter Fortune, chancellor of the University of Mississippi, has announced that the annual presentation occasion will be conducted at Jackson on March 30.

Title XIX Moves to 'Usual and Customary'

Twenty-one of 39 Title XIX programs in United States jurisdictions are compensating physicians on a basis of usual, customary, and prevailing fees. This was the announcement of the Department of Health, Education, and Welfare as of Jan. 2 in reporting progress in program implementation. Fourteen jurisdictions are making use of fixed fee schedules, one is paying on a percentage of usual, customary, and prevailing fees, and no data are reported on compensation arrangements in three states.

The report stated that two states, Connecticut and Kentucky, have only recently changed physician compensation arrangements to the usual and customary system. West Virginia accepts physicians' billings at the level of usual and customary fees but pays only 70 per cent of the billing because of funding difficulties.

Title XIX programs have been implemented in 37 states and two territories, Puerto Rico and the Virgin Islands. Both of the latter have fixed fee schedules.

States adopting the usual, customary, and prevailing fees arrangement are California, Connecticut, Georgia, Idaho, Illinois, Iowa, Kansas, Ken-

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Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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tucky, Louisiana, Maryland, Michigan, Minnesota, and Missouri.

Others are New Mexico, Oklahoma, South Dakota, Texas, Utah, Vermont, and Wisconsin. West Virginia is using the percentage of the billing as the basis for professional compensation.

States with fixed fee schedules include Massachusetts, Montana, Nebraska, Nevada, New Hampshire, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, and Washington. There were no data reported on Delaware, Maine, and Wyoming. The two territories have fixed compensation schedules.

The Carolinas, Florida, Tennessee, Alabama, Mississippi, and Arkansas make up the largest white spot on the map without currently operational Title XIX programs. Most are expected to move toward program implementation during the year.

In the Mississippi legislature, there is keen interest in Title XIX, and study groups are conducting meetings with interested organizations and agencies of state government.

Mississippi Doctor Collection Goes to UMC

A complete, 37 volume set of the *Mississippi Doctor,* for more than a generation the official journal of the state medical association, has been presented by its publisher and editor to the Rowland Medical Library at the University Medical Center. The presentation was made by Dr. W. H. Anderson of Booneville and Mrs. Anderson during a special luncheon occasion at UMC recently.



Chancellor Emeritus J. D. Williams, left, accepts the Anderson collection of the Mississippi Doctor *for UMC from Mrs. W. H. Anderson and Dr. Anderson, as Dr. Robert E. Carter, dean and director, looks on.*

The bound set was accepted for the medical center by Dr. Robert E. Carter, dean and director, and by former Chancellor J. D. Williams of the University. A special section of the Rowland library has been dedicated for placement of the volumes, marked by a permanent brass plate.

The *Mississippi Doctor* was founded by the late Dr. V. B. Philpot at Houston in 1922 and was published continually through the issue of December, 1959. The publication subsequently became the official organ for the Mid-South Postgraduate Medical Assembly and the Mississippi State Medical Association.

Called the "journal with a vision," the *Mississippi Doctor* faithfully recorded medical history in the state, advocated advances in public health programs, supported the Hill-Burton hospital construction act, and made a case for the establishment of the four year medical school at Jackson.

In the final issue, Dr. Anderson wrote that "through the past three decades, we have consistently endeavored to place Mississippi in the forefront in medical progress by lifting the standards of medical care from Possum Trot to the urban center."

Dr. Williams, now chancellor emeritus of Ole Miss, accepted the collection in behalf of the University. Also present as guests on the special occasion were Dr. John A. Gronvall, associate dean of UMC; Dr. A. L. Gray of Jackson, executive officer of the State Board of Health; Dean Christine Oglevee of the UMC School of Nursing; Dr. David B. Wilson, director of University Hospital and president of the American Hospital Association; Irene Graham, UMC librarian; and Maurine Twiss, director of Public Information at the medical center.

State Senate Urges Health Program Study

A concurrent resolution sponsored unanimously by the Senate Committee on Public Health is aimed at having Governor John Bell Williams appoint a select, seven-member committee fact-finding committee to study present programs, to back comprehensive health planning, and to support implementation of Title XIX.

The resolution, SCR 129, takes the position that "one of the most vital services that a state should provide its citizens is a comprehensive pro-

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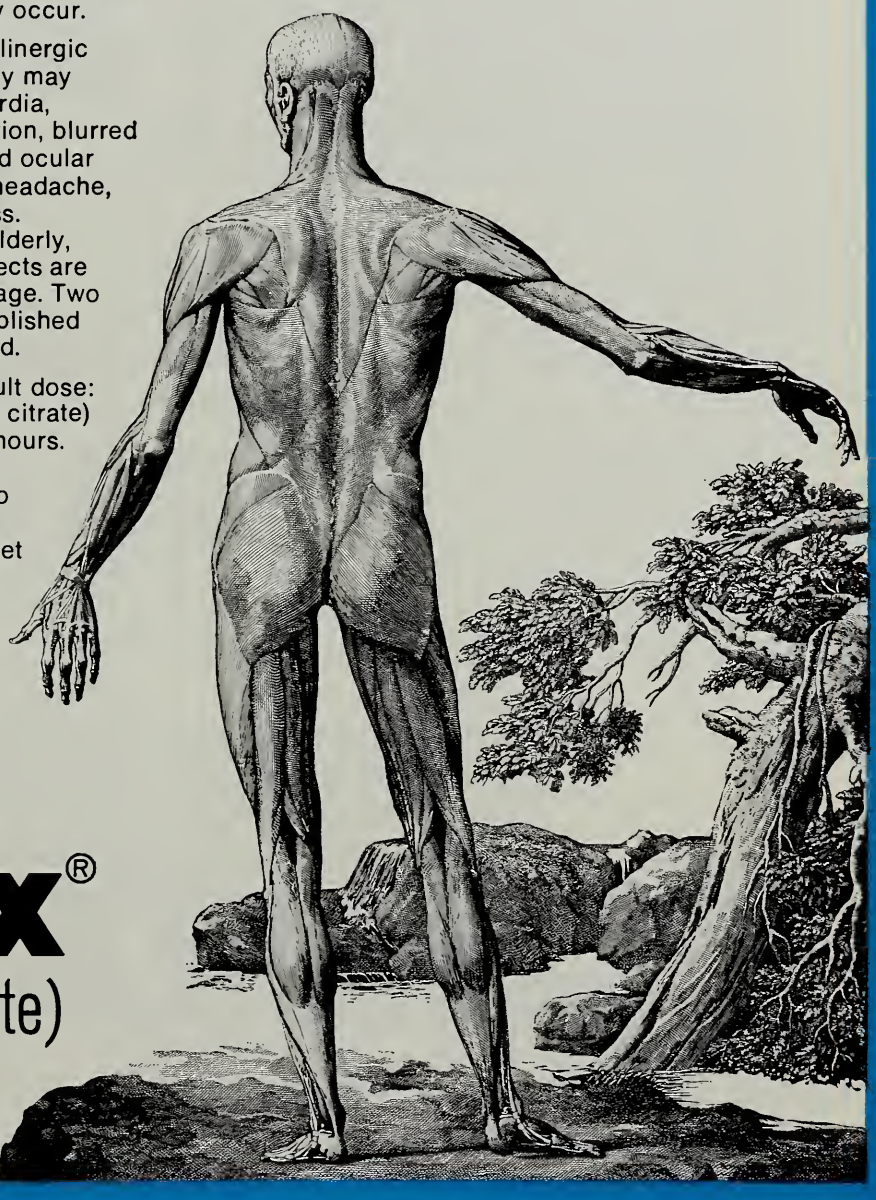
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gram of public health, a public health program whereby the state supplements, assists, and coordinates private medical and health resources to the end that the urgent and necessary health needs and requirements of the people are met in all significant areas of public health."

The committee also said that "Mississippi's total effort in the field of public health is fragmented and splintered with statutory authority being vested in several different state agencies." State medical association observers noted that the wording of the resolution parallels the wording of Dr. James T. Thompson's presidential address in 1967 when the Moss Point physician called for implementation of a medically-oriented Title XIX program and a consolidation of the fragmented, splintered programs which are scattered among many different state agencies.

The senators pointed out that Mississippi is one of the few states that does not have an overall comprehensive public health program to achieve maximum utilization of state and federal funds available for public health purposes, obviously referring to Title XIX and the comprehensive health planning amendments of 1967.

In mid-February, Governor Williams' office was designated the state comprehensive planning agency by the Department of Health, Education, and Welfare.

The resolution asks that a committee composed of not less than seven prominent citizens be named by the Governor to review all Mississippi public health resources, existing statutes in this field, and programs of agencies now administering health programs.

Six of the seven members would represent respectively, according to the resolution, the State Board of Health, state mental institutions, the hospitals of the state, the Mississippi State Medical Association, the University Medical Center, and the Mississippi Legislature.

The Governor would also have power to designate the chairman, and members of the committtee would serve without compensation.

NASA Designs Mini-Probe for Hearts

Blood-pressure sensors so small they can pass through a dog's artery into the heart have been developed by the National Aeronautics and Space Administration. Now used on research animals, they show promise as a diagnostic and monitoring instrument for humans.

The smallest of the miniature probes, less than five one-hundredths of an inch in diameter, is used by life scientists as NASA's Ames Research Center near San Francisco to make measurements on anesthetized dogs.

It is inserted through an ordinary hypodermic needle into an artery and maneuvered into the left ventricle on the end of a thin flexible tube to make measurements inside the artery and the heart without disturbing the flow of blood. Its small size is expected to make the instrument particularly useful in treating babies.

The sensor is a diaphragm-type capacitance transducer mounted on the end of a cardiac catheter. It was invented by Grant W. Coon of the Ames Center, based on transducers originally designed to measure pressures on flight models in wind tunnel tests.

A similar device developed at NASA's Electronics Research Center, in Cambridge, Mass., has measured blood pressure with unprecedented accuracy inside a dog's artery and heart in tests conducted with Harvard Medical School. The tests gave promise of combining the sensor with a transmitter so that it could be permanently implanted in a human body for continuous monitoring while the subject moved about freely.

Rehab Services Guide Is Published

Population, economics, and incidence of crippling as well as other factors related to the needs for rehabilitation services throughout the United States are brought together in a new booklet published by the National Easter Seal Society for Crippled Children and Adults.

The 92-page guide to needs and resources in the rehabilitation field includes descriptions of the services of the major voluntary and tax-supported agencies supplying or supporting rehabilitation services.

Titled "Trends Affecting Program Planning in Easter Seal Societies," the booklet was produced primarily for use by staffs of the more than 2,000 facilities and programs of the Easter Seal Society in all states. But, according to Miss Eleanor Bader, director of the National Society's Care and Treatment Service, will be useful to any agency in the rehabilitation field.

The ninth annual edition of "Trends" contains statistical data on population, health and welfare expenditures, and incidence of crippling from disease and accident, projecting present and future

health and manpower needs. It points out, for instance, that some quarter million babies are born each year with crippling conditions, and that these numbers will grow rapidly with the so-called population explosion.

The book individually describes the rehabilitation programs of tax-supported agencies, major national voluntary health agencies and service organizations, outlining specific programs, listing chief personnel and amounts expended.

NACC Releases Progress Report

The National Advisory Cancer Council has released its second public report on the state of the art in cancer research.

"Progress Against Cancer, 1967" deals largely with research on viruses as cancer-causing agents in laboratory animals and the efforts being made to identify viruses that may give rise to malignant diseases in man. Progress is other areas of cancer research is also described.

The council, established by the National Cancer Institute Act of 1937, advises the Surgeon General of the Public Health Service on general policies, programs and needs, and reviews research developments and their application to the cancer problem. Its first published report, "Progress Against Cancer, 1966" was issued a year ago under the Council's authority to collect information on cancer research and make it available to health agencies, physicians, research scientists and the general public.

The 65-page current report emphasizes that no virus has been identified as the causative agent in any form of human cancer. However, since viruses are known to cause a variety of cancers in lower animals, many scientists believe they are also one of the causes of cancer in man. With this as a working hypothesis, investigators are carrying out many lines of research, including the development of an immunizing technique or agent, such as a vaccine, that could prevent virus-caused malignant disease.

"Progress Against Cancer, 1967" is fully illustrated and includes an extensive bibliography on virus-cancer research. Listed as Public Health Service Publication No. 1720, it can be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. The price is 65 cents per copy.

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Dr. Felts Wins Hall of Fame Honors

Dr. Nollie C. Felts of Hattiesburg is one of five Mississippians compiling outstanding records in athletics who will be installed in the Hall of Fame on April 8. Others to be honored include J. A. (Junie) Hovious of the Ole Miss coaching staff; H. L. (Hook) Stone of McComb, former baseball and football great of Mississippi State University; S. B. Vick of Pope, legendary .500 hitter and 1.000 fielder at Millsaps; and the late B. F. (Spec) Wilson of Laurel, famed football player and golfer.



Dr. Felts

At the Tulane University, Dr. Felts lettered in three sports and was All-Southern fullback in 1930. In 1931, he was All-American and the key man in the Tulane steamroller offense when the team went to the Rose Bowl undefeated. He was captain of the football team in his final year.

Prior to going to Tulane, Dr. Felts attended the University of Southern Mississippi, then Mississippi Southern College, where he also played football. He has been physician to USM athletic teams since 1937, serving without compensation.

The announcement of the Hall of Fame awardees was made by Ray Thornton of Jackson, president of the Jackson Touchdown Club, and William Winter of Jackson, chairman of the Hall of Fame Committee. Awards and installations are scheduled for the annual banquet on April 8 when 1,000 are expected.

Hall of Fame members are selected on the basis of outstanding records in amateur or professional sports as either players or coaches. No athlete is eligible until he has been out of competition for five years, and no coach is eligible until he has been out of coaching for three years.

Nominees must also meet the criteria of having "the attributes and attainments of character, leadership, and American citizenship."

Dr. Felts received his medical degree from the Tulane University School of Medicine in 1935 and has practiced continually since 1937 at Hattiesburg. He is a member of the South Mississippi Medical Society, the state association, and AMA.

Tobacco-Health Study Is Given Impetus

Is smoking a psychologic addiction with deadly overtones or more in the nature of a bad habit?

The best estimate of clinicians and scientists in the field is that cigarets are a health hazard. But they admit they don't have the scientific data yet to establish why and how.

The problem is one that must be answered at the cellular and molecular level. What effect is produced by the molecules that constitute cigaret smoke on the molecules that make up human cells?

For the past three years, wide ranging research into many questions at this level has been sponsored by the Project for Research on Tobacco and Health of the American Medical Association-Education and Research Foundation. But direct and incontrovertible evidence for a cause and effect relationship between smoking and disease—including cancer, respiratory and cardiovascular disease—is difficult to obtain. The answers are probably still years away.

Nevertheless, the program has already met with a degree of success, according to its architects.

Explains Dr. Maurice H. Seevers, chairman of the Committee for Research on Tobacco and Health: "For one thing, the program has helped stimulate an interest in laboratory research on smoking."

In the past research into the effects of smoking has often been retrospective in nature—attempting to correlate certain diseases with smoking patterns on a statistical basis.

There was, however, only spotty interest among scientists in laboratory investigation of the questions posed by the statistics.

Dr. Seevers, professor and chairman of the Department of Pharmacology at the University of Michigan Medical School, said grants provided under the AMA-ERF program are designed to change this by making it possible for scientists to undertake long-range studies.

"Our goal has been to stimulate such interest among established researchers," he said.

The decision to include cardiovascular and respiratory research in the program along with cancer, he explained, was based on the fact that certain respiratory and circulatory diseases show

much the same statistical relationship to smoking as cancer, and at the same time are more prevalent than cancer.

The Project for Research on Tobacco and Health was initiated by the AMA House of Delegates as an adjunct to its educational campaign to discourage the use of toxic materials—including tobacco—among young people.

The indictment of cigaret smoking as "a serious health hazard," was restated following the Surgeon General's report citing the statistical relationship between smoking and lung cancer and other diseases.

At that time, however, the AMA delegates made it clear they did not think the report could stand alone. It needed facts to back it up.

They indicated that statistical tabulations alone were not enough to dissuade smokers from their habit. The role of smoking as a causative factor in death and disease—the mechanisms by which tobacco smoke attacks the body and the chemical agents, if any, responsible for the damage—also would have to be defined if any educational campaign were to be successful, they said.

Much of the support for the research project was furnished by the tobacco industry itself, which pledged $10,000,000 over a five-year period. Industry interest was in settling once and for all the question of whether smoking is or is not the cause of certain diseases. Furthermore, the tobacco firms wanted to know if smoking was implicated in disease, was it due to some specific agent or agents in the tobacco which could be removed from the smoke.

As Dr. Seevers explained: "While the medical profession and tobacco industry have somewhat divergent reasons for promoting tobacco research, both are committed to basic scientific research as the best means of developing specific answers to the questions raised by our smoking population."

"Certainly there are no scientific data that would contradict the basic tenets of the Surgeon General's report," he added.

"I believe very few, if any, of the scientists working under this program would advise anyone to smoke. Still we hope that in a search for facts, we can retain an open mind."

All grants awarded under the program rest with the AMA-ERF and the research committee headed by Dr. Seevers. Other members of the committee are Drs. Richard J. Bing, professor and chairman of the department of medicine, Wayne State University; Robert J. Hasterlik, professor of medicine

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at the University of Chicago School of Medicine; John B. Hickam, professor and chairman of the department of internal medicine, Indiana University Medical Center; Paul S. Larson, professor and chairman of the department of pharmacology, Medical College of Virginia, and Paul Kotin, director of the National Environmental Health Science Center, Chapel Hill, N. C.

To date 79 grants have been awarded, including four in foreign countries, and a total of $6,090,886 committed to research projects.

Goals and guidelines laid down for the awarding of grants are centered on "efforts to encourage and support studies to determine which significant ailments might be caused or aggravated by smoking . . . those mechanisms by which cigaret smoking might affect health . . . and the particular substance or substances in smoke which might be the causal or aggravating agent."

Dr. Steinberg Heads AHA Council

Dr. Daniel Steinberg, chief of the Laboratory of Metabolism, National Heart Institute, U. S. Public Health Service, has been elected chairman of the Council of Arteriosclerosis of the American Heart Association.

The Council, one of seven of the American Heart Association, guides the group in research, policy, and community medical programs related arteriosclerosis. This year the council will begin a new diet program to determine the best possible dietary regimen for patients with arteriosclerosis and to recommend this diet to physicians for their patients.

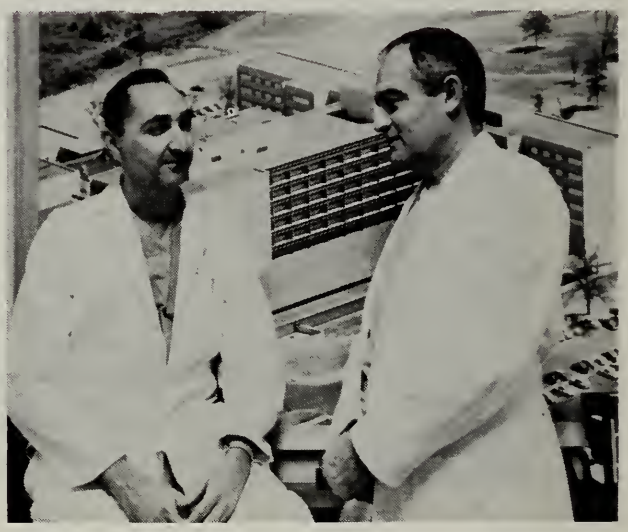
Dr. Steinberg's work at the National Heart Institute has centered on the biochemical pathways of lipid metabolism and the biosynthesis of sterols, including cholesterol, as they relate to coronary heart disease and atherosclerosis.

His early interest in drugs affecting cholesterol synthesis led the way to development of this therapeutic approach to lowering levels of cholesterol in the blood. His experimental studies with the cholesterol-lowering drug MER-29 led to the disclosure in 1961 of the agent's biochemical mechanism of action. Although the drug did, in fact, lower serum cholesterol levels by blocking the synthesis of cholesterol at desmosterol, Dr. Steinberg, and his colleague Dr. Joel Avigan, showed that desmosterol substituted admirably for cholesterol in the build-up of atherosclerotic plaques and that the total effect of the drug was to exchange one villain for another, plus side-effects. Newer drugs under study, such as Atromid, can inhibit chemical synthesis without the undesirable accumulation of intermediate compounds.

Recently, Dr. Steinberg and his group have worked out the biochemical steps in the breakdown of phytanic acid, a lipid that accumulates in the blood and tissues of patients with Refsum's syndrome, a rare, inherited neurologic disease. Dr. Steinberg's group recently announced their identification of the exact nature of the enzyme defect in this disease, using tissue culture techniques. Since this is the first case in which the biochemical basis of a demyelinating disease of this type has been established, it is hoped that the findings will give clues valuable in study of related disorders as well.

One of the goals Dr. Steinberg has set himself during his tenure as chairman of the Council on Arteriosclerosis is to encourage the development of centers in which biochemists and experimental pathologists can work together more effectively in studying the sequence of events that lead to arterial damage and the ultimate development of atherosclerotic lesions.

Cornell Professor Is UMC Guest Lecturer



Dr. Leonard Fabian (left), professor of anesthesiology and department chairman at the University Medical Center, talks with guest lecturer Dr. Joseph Artusio, visiting professor of anesthesiology, prior to a recent UMC seminar. Dr. Artusio is professor of anesthesiology and chairman of the department at Cornell University Medical College.

Energy Conversion Is Reported by NHI

Scientists of the Public Health Service's National Heart Institute report that the failing heart converts chemical energy to mechanical work at least as efficiently as does the normal heart. Previously, the fundamental biochemical defect in heart failure had been attributed by many to a defect in energy utilization.

This defect is now thought to be either in the contractile proteins actin and myosin, which are the basic elements of contraction of the heart muscle fibril, or in the process of excitation-contraction coupling, by which the heart muscle is activated. In excitation-contraction coupling, calcium within the muscle is released and in turn causes a release of energy for the heart's contractions. This energy release causes the muscle to contract.

In order to determine whether there was any defect in energy transfer in the failing heart, Dr. Peter E. Pool and co-workers at National Heart Institute studied the direct conversion of chemical energy to mechanical work in right ventricular papillary muscles from normal cats and cats with experimental right ventricular failure.

Papillary muscles are the muscular eminences in the ventricles of the heart which, in combination with the atrioventricular tendons cause the cardiac valves to open and close. These muscles were used in this study because they are of a convenient size and also because all of their fibers are parallel, making it easy to measure the amount of work done in pulling in one direction.

The papillary muscles were treated to prevent the production of ATP from the metabolism of foodstuffs. The muscles were then stimulated to perform work by pulling against a load, and the amount of work was measured. They were then frozen and analyzed to determine the amount of ATP present. This gave a measurement of the amount of energy burned. The investigators found that failing heart muscles and normal heart muscles used the same amount of ATP energy per unit of work. This indicates that the failing heart converts chemical energy to mechanical work as efficiently as the normal heart.

Since the biochemical defect in heart failure is not in energy utilization, the National Heart Institute investigators postulate that the defect must be either in the contractile proteins or in excitation-contraction coupling.



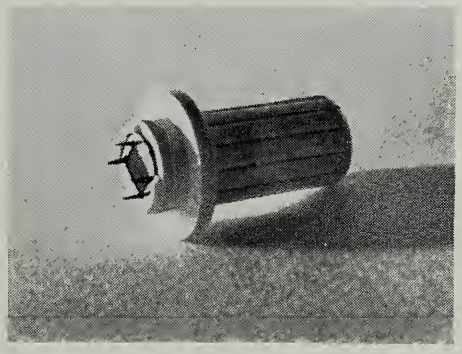


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Survey Shows Epileptics Guard Secret

A study of how university-educated epileptics operate in society reveals that many of them are doing fine, but they don't like to talk about their affliction.

Dr. Joseph P. Miranti, of the Southern Illinois University Health Service, draws these conclusions in a scientific article in the January issue of *GP* magazine, official scientific publication of the American Academy of General Practice.

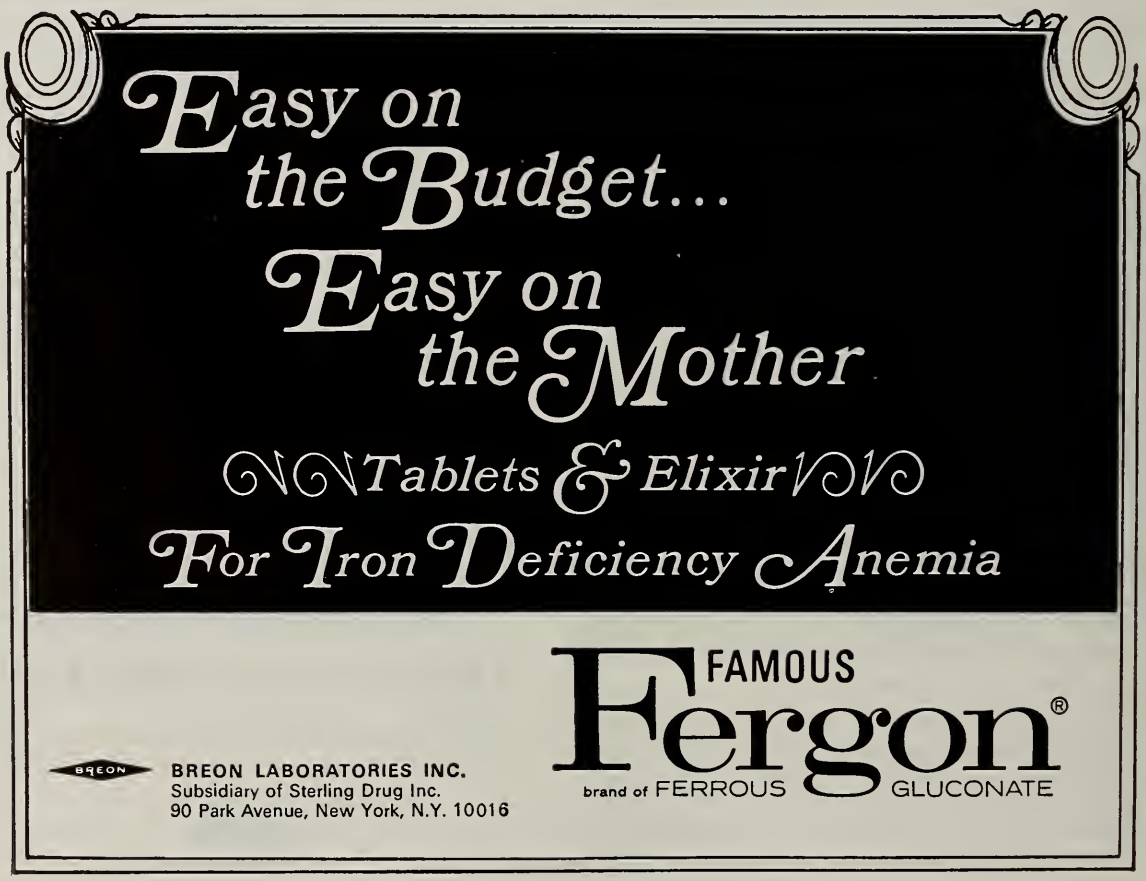
Dr. Miranti bases his conclusions on a survey of 44 known epileptics who were attending or had attended S.I.U. during the past nine years. In response to a personal letter of explanation and invitation, exactly half of the 44 agreed to participate in a study of their adjustment to society. However, only 12 of these 22 individuals actually were willing to answer a questionnaire sent to them, Dr. Miranti reveals in the article.

Of the dozen persons aged 21 to 32 who completed the questionnaire, only four had informed their employers about their disease, and two of the seven married epileptics had waited until after marriage to tell their spouses, the survey showed. The majority remained on medication after college, but only four saw a private physician.

The controlled, university-educated epileptic, Dr. Miranti suggests, is secretive about his ailment out of necessity. He must protect himself from a society in which he still has difficulty obtaining a driver's license, insurance, and a job as a teacher or factory worker. A known epileptic who may have an occasional seizure cannot become a priest, the author states.

"University training should be a part of the usual rehabilitation of the capable person who happens to have convulsions," the author states. Although epileptics perform as well as other students (more than 1 in 1,000 students at S.I.U. is epileptic) the continuing increase in university applicants increases the danger the epileptic will have difficulty obtaining a higher education, he warns.

The survey respondents included three teachers, a speech therapist, a rehabilitation counselor, a graduate student and several business and industrial workers.



SBH Cracks Down on Auto Graveyards

Newest enemy of the abandoned auto blight is the Mississippi State Board of Health. V. T. Hawkins, the board's state advisory sanatarian, said that the interest of the state health agency is not aesthetic but that of the public health.

Hawkins reported a survey by the State Board of Health in 72 Mississippi communities which showed that one residence out of eight has an abandoned motor vehicle on the premises. The board defines such a car as one in a state of disrepair so as to be incapable of moving under its own power.

Abandoned autos harbor disease-bearing insects, Hawkins said. The clunkers have yielded up healthy samples of the *Culex tarsalis,* a principal vector of encephalitis, and the *Aedes aegypti,* a carrier of yellow fever and dengue. The abandoned wrecks also harbor rats and are dangerous to the curious and salvage-seekers.

The State Board of Health said that the environmental survey was the first step in the clean sweep campaign. City ordinances prohibiting car abandonment on residential property will be sought, and studies are underway to discover the best means of disposing of the old cars.

U. S., India Work in Cancer Research

The Indian government's Central Drug Research Institute at Lucknow has renewed its agreement with the National Cancer Institute, National Institutes of Health, to study native Indian plants as a source of potential anti-cancer drugs. A U. S. Public Health Service contract, using blocked dollars available under Public Law 480, is providing $136,000 (1,020,400 rupees) to finance the next 3 years of investigation.

Under the program the Indian research center, directed by Dr. M. L. Dhar, collects indigenous plants and from them prepares extracts for study by the National Cancer Institute in Bethesda, Maryland. Dr. Jonathan L. Hartwell, project officer for NCI and head of its Natural Products Section, has the extracts tested for their ability to inhibit animal cancers. Any that show effective-

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ness are re-collected by Indian botanists, re-extracted and fractionated by Indian chemists, and individual fractions are screened against animal cancers to identify active agents.

Of more than 600 plant materials studied by the Indian laboratory during 4 previous years of contract-supported research with U. S. scientists, 14 plants were identified with confirmed activity against animal cancer. Ten are still under study although they have not as yet been evaluated clinically. Plant extracts are considered a promising source of possible anti-cancer drugs, since one of the best-known agents, Vincristine, was derived from an extract of the periwinkle plant. Indian plants have already yielded medically useful extracts for treating other diseases, for instance, rauwolfia compounds for treatment of hypertension.

In addition to research with plants, the Central Drug Research Institute is also preparing to synthesize chemical compounds for testing in the U. S.-India program. It is anticipated that Indian chemists may produce new and varied materials for screening in animals and for possible use in human cancer.

SKF Instrument Has New Diagnostic Role

The Doptone Blood Flow Detector, introduced last year by Smith Kline Instrument Co., now has a new use in diagnosing and evaluating common diseases of the veins of the leg.

The new application for the ultrasound instrument was discussed Monday in a presentation delivered by Dr. Bernard Sigel, associate professor of surgery at Woman's Medical College of Pennsylvania, at the American College of Surgeons meeting in Chicago. It was also the subject there of a scientific exhibit by Dr. Sigel.

Smith Kline Instrument of Philadelphia, which manufacturers and markets the portable instrument, originally introduced it for use by surgeons in detecting obstruction in the arterial system. SKI is a Division of Smith Kline & French Laboratories, Philadelphia manufacturer of prescription drugs and other health-related products.

Another Doptone instrument, the Doptone Fetal Pulse Detector for use in obstetrics, also was introduced last year by SKI. Both instruments employ the "Doppler effect," which is the change in frequency of sound waves when the source of sound, the listener, or both are in motion.

Dr. Sigel contends that the Doptone method of diagnosing diseases of the veins is highly accurate, simple, and skill in its use may easily be acquired. This method involves locating and identifying sounds made by the flow of blood through veins and enables the physician to detect blockages and incompetent valves in the veins.

By applying the Doptone instrument's transducer—its listening device—to the suspect leg and compressing the muscle mass above and below each of three test sites, the doctor may diagnose the problem quickly and accurately.

The examination causes no discomfort to the patient and can be performed while he is bedridden.

Before this method was devised, there were several diagnostic techniques available. One was physical examination which is considerably subjective. Phlebography—injecting radio-opaque dye into one end of a vein to watch its progress—was difficult to do, hard to interpret and often very painful. Other methods include infrared photography and thermography.

Dr. Sigel, who is engaged in a three-year study at two Philadelphia hospitals (Woman's Medical College of Pennsylvania and Veterans Administration), hopes to prove that the Doptone method can be used for quick screening of all bedridden patients to diagnose venous disease before it causes unexpected calamity. The veins of the leg are the source of many of the clots that detach and become pulmonary emboli.



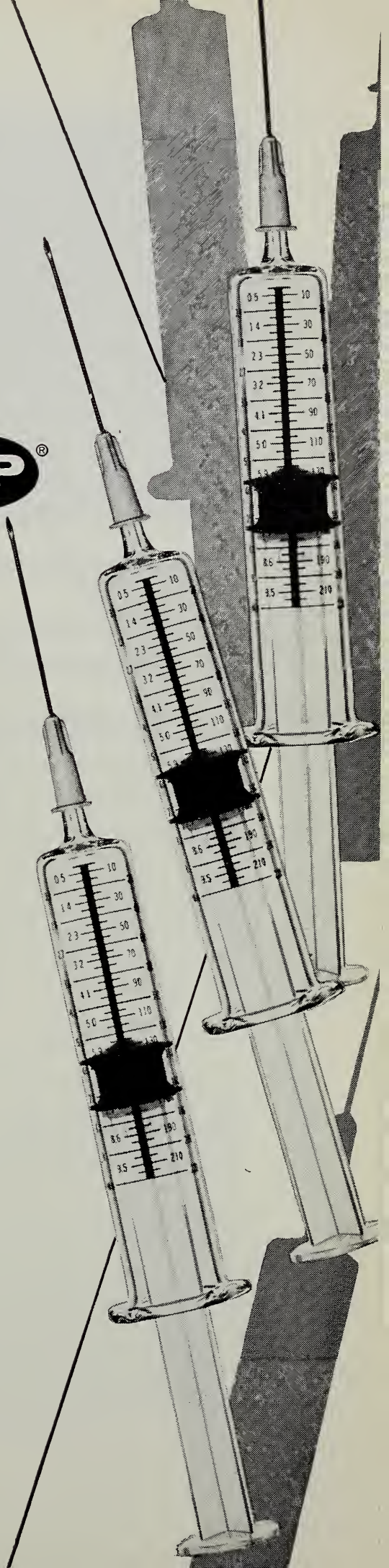
The transducer for the Doptone Blood Flow Detector is applied to the surface of a patient's suspect leg to help in diagnosing and evaluating a diseased vein. By compressing the muscle mass above and below each of three test sites at the same time, the problem may be diagnosed.

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AHA Releases Nursing Service Studies

Hospitalized patients 65 and over receive at least 36 minutes more of nursing care per patient per day than do other adults, a study by the American Hospital Association shows.

The study, conducted over a three-month period in 55 general short-term hospitals throughout the nation, was reported in the March 1 issue of the *Journal of the American Hospital Association.*

Hospitals—because of Medicare and Title XIX —have a particular interest in the relationship between age and the amount of nursing services received by patients. The first studies indicating that such a relationship does exist were made in 1965 in Los Angeles by the Commission for Administrative Services in Hospitals.

The AHA report pointed out that the difference in time "does not necessarily mean that care for the older group costs more per day, because the findings do not take into account the type of nursing personnel providing the care."

The article noted, however, that a cost analysis based on the category of nursing staff providing the service was made for one of the hospitals studied. The analysis indicated that nursing care for the older group did cost the hospital relatively more than care for younger adults.

Additional analyses of the study's findings will be made to determine the cost implications to the other hospitals participating in the survey. The U. S. Public Health Service is making funds available for that purpose.

Hospital administrators commonly use nursing hours per patient per day as one measure of nursing care given to patients. The measure is obtained by dividing the total working hours of all nursing service personnel assigned to a nursing unit per day by the number of patients in the unit on that day.

Using that method, the AHA survey found that slightly more than half of the 52 hospitals for which data were complete gave between four and five hours of care per patient per day to all adult patients in the nursing units studied.

Other study findings reported in the HOSPITALS article include:

Of the hours of nursing care provided per day, 52.3 per cent were scheduled during the day shift, 30.9 per cent during the evening hours, and 16.8 per cent during the night shift.

In only seven of the 52 hospitals for which data were complete did the younger adult patient group receive more nursing care than the over-65 patients.



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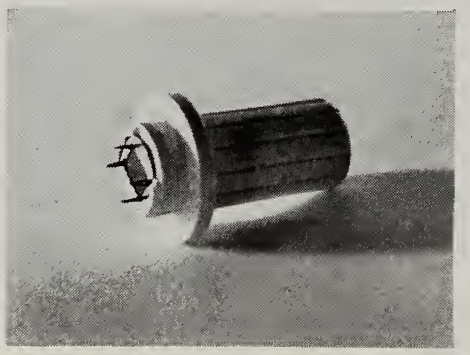
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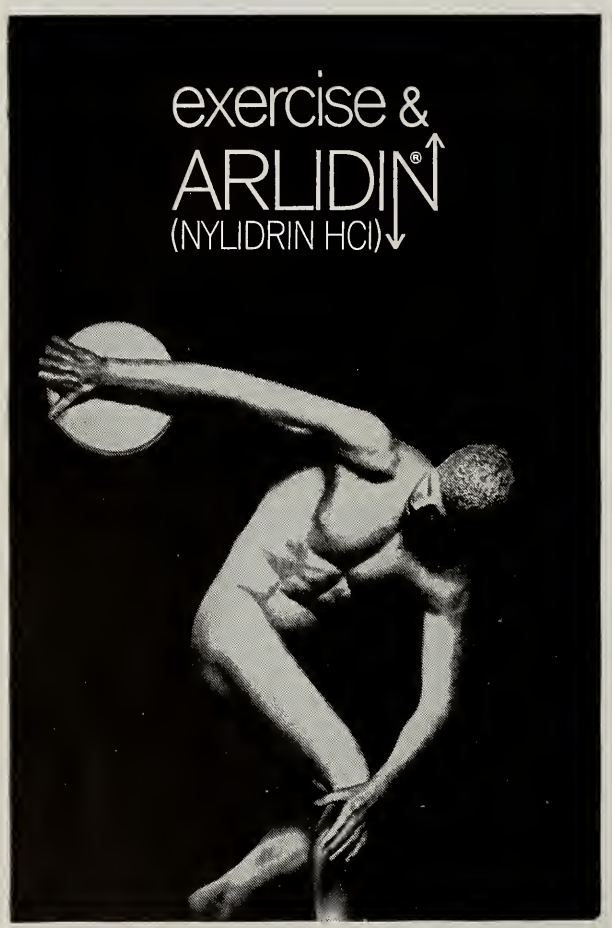


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Cardiologists Would Refuse Transplants

More than half (53 per cent) of the cardiologists participating in Marion Laboratories' monthly national physician poll would *not* consent to heart transplant surgery if they had advanced heart disease with a poor prognosis.

Only 27 per cent of the heart specialists in the Playback doctor panel stated that they *would* consent to heart transplantation, with 20 per cent undecided.

The negative response of non-heart specialists was similar, but to a lesser extent, Forty-two per cent of these doctors (GPs, specialists in internal medicine, neurology, psychiatry, orthopedics and obstetrics-gynecology) indicated that they would not consent to transplantation, while 36 per cent said yes and 23 per cent said no. The Playback panel consists of 9,500 doctors nation-wide. The responses tabulated in this report include 218 cardiologists (from 800 polled) and 2,103 other physicians (from 8,700 polled).

The Playback poll asked those physicians who answered no to the question on consent to transplant for the reasons *why* they answered in the negative.

"Rejection phenomenon" was the reason listed most often by respondents (44 per cent of the cardiologists, 34 per cent of the non-heart specialists).

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Syntex Laboratories will begin selling its pill-a-day oral contraceptive, Noriday, in the United States, it has been announced by Paul O. Bancroft, vice president and general manager of the Pharmaceutical Division.

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Contraindications Known hypersensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, in premature or in newborn infants during first week of life.

Warnings As with other forms of sulfonamide therapy, use only after critical appraisal in patients with liver or kidney damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests when used intermittently or for long periods.

Precautions, Side Effects Use sulfonamides with caution in patients with a history of allergy, including asthma. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent; if encountered appropriate countermeasures (e.g. epinephrine, steroids, etc.) should be administered and the drug withdrawn. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. In prolonged therapy, or when high dosage is used, maintain an alkaline urine. If oliguria occurs, discontinue therapy. Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin; generally improved by reduction of dosage.

If overgrowth of nonsusceptible organism occurs, withdraw the drug and institute appropriate treatment.

Adverse Reactions Sulfonamide therapy may be associated with headache, nausea, vomiting, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, urticaria, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria. 803446

ABBOTT

State Cancer Society Wins Crusade Honors

The Mississippi Division of the American Cancer Society has won first place nationally in the annual Cancer Crusade by nosing out Rhode Island 1.2 percentage points. It was the second consecutive year that the Mississippi Division topped the national competition.

The Mississippi group scored 103.9 per cent, and second place Rhode Island came in with 102.7 per cent. The silver trophy was received by the Mississippi Division for the second year, according to Dr. Guy T. Gillespie of Jackson, president.

The 1968 crusade was kicked off last month with the annual meeting of volunteers conducted at Cleveland, Ohio, Dr. Gillespie said.

MIC Says Centers Will Treat Alcoholics

The Mississippi Interagency Commission on Mental Illness and Mental Retardation says that all developing comprehensive regional mental health centers in the state will provide services to alcoholics. The new program, according to MIC spokesmen, represents a major policy decision of the commission.

Dr. Dorothy N. Moore of Jackson, MIC program director, said that "this decision puts alcoholism squarely in the same category with other health and social problems, as it should be, rather than isolating it, as it has been in the past.

"Such isolation only increases the stigma attached to alcoholism and encourages those who would ignore it instead of recognizing it as a legitimate community concern."

The statement continued by charging that separate programs for alcoholism make it too easy for other community agencies to conclude that alcoholism is not their concern.

Dr. Moore said that "the immediate effect will be to encourage general hospitals to open their doors to alcoholics for treatment under that specific diagnosis, which has not always been the procedure in the past."

The statement said that the wider range of service will enable the patient to be seen as a total person, to realize his needs, and to treat him on that basis, rather than just "on the basis of the label, alcoholic."

AMA Increases Medical Film Service

The growing increase in the number of excellent medical teaching films over the past several years is reflected in the rise in requests for motion pictures from the Film Library of the American Medical Association.

In addition, there is a greater appreciation of the value of well-prepared motion pictures in graduate and postgraduate medical education, according to Ralph P. Creer, director of the medical motion pictures and television section of the AMA.

As a further indication as to the need for motion pictures by physicians and paramedical schools (allied professions; other than physicians), the supply of the Catalog of Selected Medical and Surgical Motion Pictures was exhausted within six months, and thus went out of print.

It is especially gratifying to note that many schools have requested the same motion pictures over a period of several years, indicating that these films have now become integrated into the school curriculum, Mr. Creer said.

A total of 17,328 medical and health films were lent to physicians, hospitals, medical schools or other professional groups by the AMA Film Library during 1967.

Most of the film were employed as educational material for physicians, medical students, nurses and paramedical students.

The number of bookings was the greatest ever recorded at the library, increasing 23 per cent over 1966 and 49 per cent over 1965. Total bookings have increased each year since 1955 when 3,007 were recorded.

Analyzing 1967 film bookings further, he said that the largest single users of films from the AMA library were civilian hospitals and schools of nursing. Ninety-two U. S. medical schools used the services of the Film Library during the year. Paramedical schools were increasingly heavy users, accounting for over 10 per cent of the total bookings.

The library now consists of 2,453 copies of 502 films. The total includes 128 health films which can be used by physicians who are invited to address lay groups. A current list of these films is now available.

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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

April 1968

Dear Doctor:

President Johnson fired the opening gun in what looks like an all-out attack on the costs of medical care in his March 4 message to Congress. The two-pronged proposal authorized HEW to experiment with new tests of "incentives designed to reduce Medicare costs," including reduction of so-called unnecessary hospitalization.

> The President also said he would ask the Congress to authorize "new payment methods" for Medicare and Title XIX. Most observers interpret this as a trial balloon or even a threat for future maximum fee schedules. No such bill has - as yet - been introduced.

Mississippi physicians are urged to complete professional activities survey form in March 18 AMA News and send it to Chicago headquarters. Basic purpose is to update personal and professional data for the 1969 American Medical Directory. Secondary purpose is to develop new facts on physicians' activities, practice patterns, and teaching work.

Federal spending for the mental health and retardation programs for 1969 will grow by $37.5 million over current year. Overall appropriation is $1.46 billion, an amount which tops the foreign aid program by $200 million. Biggest single item in astronomical budget is $433.5 million for National Institute of Mental Health which includes state grants for community mental health programs.

Forty New York state senators and assemblymen (representatives) have enrolled in a six week course to break the smoking habit. Unique program was proposed by state health department and is conducted by a physician for the legislators once weekly at the Albany state capitol building. A previous trial course drew an enrollment of 20 members and was deemed successful.

Chiropractors are busy in the halls of the legislature at Jackson, promoting their biennial licensure attempt. Most effective answer - as before - is for physicians to talk to senators and representatives at home, giving them the facts on these cultists. Every contact by a physician in the legislator's hometown is valuable.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

ACS Reiterates Policy On Publicity

Chicago - The American College of Surgeons Board of Regents has reaffirmed its standing policy that "immediate or instant publicity with respect to the performance of new surgical procedures is not in the best interests of patients." The Regents said that announcements of new innovations are traditionally made to professional audiences, followed by reports in scientific journals. Warning of pressures on surgeons by news media, the policy says that the surgeon has the first responsibility for avoiding unwise publicity.

Foreign Graduates Increase In U.S. Training Programs

Evanston - The Association of American Medical Colleges reports that nearly a third of the approved residencies in the U.S. are filled by foreign medical graduates who also occupy more than a fourth of the internships. Of 31,700 residencies, a total of 9,500 FMG's hold current appointments. They account for 2,800 of the 10,300 interns in training institutions. Only 7 per cent are native born Americans who received medical training in a foreign school. Total FMG's in U.S. have increased three-fold in 15 years.

U.S. Shows Decline In Cancer Mortality Among Women

New York - Studies published by the Metropolitan Life Insurance Co. show that the United States led in the decline of cancer deaths among women during the past five years with a decrease of 13 per cent. Decline was also noted in Norway, Canada, and Sweden. Death rate was static in France and Germany but rose in Italy, Israel, Denmark, and Japan.

Osteopathic-Medical "College" Is Denied Accreditation

Seattle - An order by the state board of medical examiners accrediting the Washington College of Physicians and Surgeons was set aside by the state supreme court when it was demonstrated that the "institution," which offered osteopaths a 12 week course for the M.D. degree actually had no facilities and was merely a device to carry out the D.O.-to-M.D. transition. Washington State Medical Association has endorsed inclusion of D.O.'s into ranks of medicine.

AMA Issues Health Club Warning

Chicago - Commercially-promoted "health clubs" touting weight loss programs may be dangerous for some clients, AMA has warned. Most such clubs do not require physical examination by a physician prior to enrollment, and strenuous workouts may be harmful. AMA also cautioned public that excess weight can be a symptom of illness.

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
April 1968, Vol. IX, No. 4

ORIGINAL PAPERS

Respiratory Management of the Acutely Injured Patient

C. R. STEPHEN, M.D.
Dallas, Texas

VIOLENT TRAUMA is becoming one of the hallmarks of the 1960's. The automobile is contributing its fair etiological share, but the knife and gun clubs throughout the length and breadth of the country are responsible for most of the acute injuries.[1, 2]

To preserve life in these patients, attention must be focused first on the respiratory and cardiovascular systems, for without oxygen reaching the blood stream and without its ability to be transported to the tissues, irreversible changes occur.

If the respiratory mechanics of the patient are deranged, corrective action must be immediate and definitive; the acute injury demands the practice of acute medicine. A patient with bloody, compounded maxillo-facial injuries, a patient who is gasping or apneic, an unconscious patient, a restless cyanotic patient, a dyspneic patient, needs immediate help.

The first task is to ensure the patency of the upper airway and to determine that air is reaching the alveoli of the lungs. On occasion simple extension of the head with forward pressure on the mandible will suffice to clear the upper respiratory obstruction. Under such circumstances, mouth-to-mouth respiration, or the use of an Ambu positive pressure apparatus, will move air down into the lungs of the patient. However, if blood or vomitus are obstructing the upper airway, these foreign substances must be removed by suction of by hand before air can reach the lungs freely.

If the respiratory mechanics of a patient are deranged, corrective action must be immediate and definitive. Respiratory care of the acutely injured patient must be individualized according to the individual circumstances of the trauma. The author discusses the determination of the etiology of the shock and the use of mechanical ventilation.

If these emergency measures do not suffice, an endotracheal tube must be inserted into the trachea with the help of a laryngoscope. With the tube in place, air or oxygen can be blown rhythmically into the patient's lungs.

With the establishment of the emergency airway, attention can then be directed to the perfusion of blood, and therefore oxygen, to the tissues. Adequacy of this function can be determined by an improved color of the mucous membranes of the patient, by determining the pulse rate and blood pressure, and by the state of consciousness.

From the Department of Anesthesia, Southwestern Medical School, University of Texas.
Read before the Section on Surgery, 99th Annual Session, Mississippi State Medical Association, Biloxi, May 16, 1967.

Hemorrhagic shock is often present, and this syndrome demands an immediate vein cannulation or cutdown, with the institution of blood replacement as soon as possible. As an interim measure, blood substitutes or Ringers lactate solution may be given freely.

With these definitive measures under way, examination can be directed to the extent and degree of the injuries sustained. Multiple injuries are not uncommon, and one must rule out or include trauma to the head, thorax, abdomen, extremities, and spinal cord. The etiology of the shock when present must be localized if at all possible.

Obvious penetrating wounds of the thorax, either knife or gunshot, are likely to damage the lung parenchyma, and cause pneumothorax, hemothorax, or both. In addition, of course, the heart itself may be injured, and pericardial tamponade may be present. With an endotracheal tube in place and the lungs being inflated, useful information may be obtained by inspection of the chest and auscultation of the lungs.

If one side of the chest expands more than the other with positive pressure, one must consider a hemo- or pneumothorax on the non-expanding side. Auscultation may confirm this suspicion, and x-ray may corroborate it. If positive pressure inflation becomes more difficult, and the oxygenation of the patient is not improving, the possibility of bleeding into the lung parenchyma or a tension pneumothorax must be ruled out.

TENSION PNEUMOTHORAX

Aspiration may produce increasing quantities of blood, but if the lungs are not wet, the positive pressure may be accentuating a tension pneumothorax. In this instance, a needle should be inserted through the chest wall into the pleura on the affected side; relief is often dramatic. On the other hand, lung inflation may be easy and symmetrical, but the color of the patient does not improve. Here one questions the efficiency of the cardiac action and specifically is concerned with cardiac tamponade as a cause.

If time permits, the measurement of central venous pressure by placing a catheter into the external jugular vein and down into the superior vena cava will aid in the diagnosis. When the patient is hypovolemic and without a primary myocardial defect, the central venous pressure will be low. If cardiac tamponade is present and cardiac action compromised, the venous pressure will be high. Again, aspiration of blood from the pericardium often produces dramatic results.

The decision whether to perform surgery in this type of trauma must be individualized for each patient and depends on numerous factors, principal among which is the degree of stability which develops in the respiratory and cardiovascular systems. In any event, it may be necessary to either assist the respirations of the patient or breathe for him entirely for some hours or days in order to provide adequate oxygenation and elimination of carbon dioxide without undue strain. This aim is achieved by instituting some type of mechanical ventilation.

CRUSHING INJURY

Treatment of the crushed chest, or flail chest, or steering wheel injury, must be vigorous if lives are to be saved. Patients with such injuries have lost the integrity of their thoracic cage and therefore have difficulty in moving air into the lungs with inspiratory efforts. They are restless, dyspneic, usually cyanotic, in severe pain, and show paradoxical movements of the chest wall, in that it tends to draw inward rather than expand during efforts at inspiration. The extent of the injury may not be apparent on physical examination. Even though there may not be much displacement at the site of rib fractures, severe pulmonary contusion or "bruising" may be present.[3]

These patients require endotracheal intubation and the institution of intermittent positive pressure breathing.[4] Only in this way can the lungs be ventilated adequately, the work of breathing reduced, and the pain of vigorous breathing efforts relieved. With such aid, a restless, distressed patient may quickly become relaxed and fall asleep.

On the other hand, there may be difficulty in adapting the patient to the ventilator, and small intravenous doses of a narcotic may be required to prevent the patient "fighting the respirator." Ventilator therapy may be required for one to two weeks because it may require this length of time to restore the ability of the thorax to create negative pressure and expand the lung during the inspiratory effort.

DECISION ON TRACHEOSTOMY

After approximately 48 hours, a decision should be made whether to continue therapy via the endotracheal tube or to perform a tracheostomy. If it is believed that mechanical assistance will be required for several more days, a tracheostomy should probably be performed. While the patient is receiving ventilatory aid, the vital signs must be watched carefully and constantly. There is always danger of a sudden tension pneumothorax de-

veloping, and this may lead to an acute respiratory crisis which is made worse with positive pressure ventilation. Another complication which affects primarily the sensorium is fat embolism, which may develop following multiple rib fractures.

Assistance of the ventilatory efforts is required in any acutely injured patient who is having difficulty in performing gas exchange through the lungs. This difficulty may be manifest, as when dyspnea and cyanosis are present, or it may be masked by unconsciousness or the shock syndrome. It is not enough merely to enrich the air the patient is breathing with oxygen; the exchange of air to and from the lungs must be boosted.

Any physician can provide this help, but it is best supervised by an anesthesiologist who is thoroughly familiar with the problems involved because he is concerned with them in his everyday work. The simplest way of assisting respiratory exchange is to interpose a reservoir bag and a nonrebreathing valve between a source of oxygen and the endotracheal tube and to rhythmically squeeze the bag and so inflate the lungs of the patient. The bag should be compressed to the point that the chest expands in a obvious manner.

MECHANICAL VENTILATORS

This manual assistance to ventilation cannot be carried out indefinitely by the human hand, so mechanical ventilators have been devised as substitutes. These are of two principal types—the volume controlled, pressure variable, and the pressure controlled, volume variable.

In the first type (Morch, Emerson, Engstrom), one can adjust the apparatus to give a definite, predetermined tidal volume to the patient with each inspiration: the machine will automatically vary the pressure required to deliver that tidal volume. This type of apparatus is particularly valuable in crush chest injuries, where the compliance of the lungs and thorax, i.e., the pressure required to deliver a certain tidal volume, may vary frequently.

These ventilators have the disadvantage that they act independently of the patient's spontaneous respiration and will not adapt to it. For this reason, when using a ventilator of this type, one usually abolishes the spontaneous respiratory efforts by combining the use of narcotic drugs to depress the respiratory center and employing hyperventilation, which reduces the carbon dioxide tension in the blood and hence reduces the activity of the respiratory center.

In order not to compromise venous return to the heart, and hence cardiovascular dynamics, the inspiratory phase of the respiratory cycle should not last more than one-third of the total cycle. Thus, if the patient is being ventilated at a rate of 20 per minute, each respiratory cycle will last three seconds, and each inspiratory phase should last only one second.

BIRD, PURITAN TYPES

The second type of ventilator (Bird, Puritan) permits the physician to set the pressure at which he wishes to force the air into the patient. The volume delivered will depend upon this pressure and the resistance encountered in the lungs and thorax. This ventilator will either control or assist the respirations of the patient. It is capable of being triggered by the negative pressure resulting at the beginning of a spontaneous respiration and will augment the amount of air moved into the lung with each respiration. These ventilators are most useful in the less critically ill patient.

It is often a problem to decide how to adjust the ventilator and how much oxygen to provide in the inhaled atmosphere. Certain information can be obtained from clinical signs, but the one certain way to monitor the efficacy of ventilator therapy is to obtain serial arterial blood samples and to analyze them for pH, carbon dioxide tension, and oxygen tension. These values can now be determined quickly in a well-equipped clinical laboratory.

In the acutely injured patient, the normal cough mechanism may be absent, and so it may be necessary to aspirate the tracheobronchial tree at regular intervals in order to remove retained secretions. The aspiration should be performed under sterile conditions with sterile catheters to reduce the possibility of introducing infection into the lungs. Negative pressure through the catheter should not be applied for more than 20 seconds at a time because it is constantly aspirating air as well as secretions; too prolonged suction can accentuate existing hypoxia. Following aspiration, the lungs should always be inflated well with oxygen.

MIXTURE HUMIDIFICATION

The mixture of air and oxygen being supplied by the ventilator should always be well humidified because the oxygen is extremely dry and the presence of the endotracheal tube or the tracheostomy bypasses the normal humidifying mechanisms of the upper respiratory passages. Nebulizers which divide up the water into small droplets are most frequently used today. The newer ultrasonic vaporizers are under study at the present time.

SUMMARY

Respiratory care of the acutely injured patient must be individualized according to the individual circumstances of the trauma. Consultation with an anesthesiologist at an early phase of therapy is beneficial as he is concerned with respiratory care every day. These should be no hesitation in initiating assisted or controlled ventilation whenever acute respiratory insufficiency exists. The efficacy of any type of ventilator care is best monitored by serial determinations of arterial blood gas values. ★★★

5201 Harry Hines (75235)

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FORM 1040¼

With the April 15 deadline bearing down on harried taxpayers, many will be glad to learn that the Internal Revenue Service has just devised the ultimate in abbreviated tax forms. In fact, it contains only three questions:

(1) How much money did you make in 1967?
(2) Where is it now?
(3) When can we get it?

Symptomatic Management of Upper Respiratory Allergies

ELLIS M. MOFFITT, M.D.
Jackson, Mississippi

CLINICALLY, ALLERGIC disorders of the upper respiratory tract account for over 50 per cent of the allergies encountered in practice. Because of this high incidence and the common difficulty in establishing the specific etiology, symptomatic management is of considerable importance to both the patient and physician. Symptomatic control is usually directed to the relief of vasodilatation, reduction of edema and hypersecretion of the mucous membranes, facilitation of drainage, and reduction of histamine activity.

The present study was undertaken to assess the effects of Ru-Tuss tablets in producing relief in a wide variety of upper respiratory allergic disorders.

One hundred and fifty-four patients, 60 male and 94 female from 12 to 68 years of age (average, 35), were selected for study from the clinical practice of allergy. Perennial and seasonal allergic rhinitis, either alone or with some other allergic upper respiratory disorder, was the most common clinical condition encountered (101 patients). Other conditions included sinusitis (29 patients), post nasal drip (7), asthma (3), and bronchitis (3 patients). Upper respiratory infections with allergic components, and food allergy with upper respiratory manifestations, were also seen in this group.

In 134 patients the dose consisted of a single, prolonged-action Ru-Tuss tablet morning and evening. Each tablet contains:

Phenylephrine hydrochloride	25 mg.
Phenylpropanolamine hydrochloride	50 mg.
Chlorpheniramine maleate	8 mg.
Hyoscyamine sulfate	0.1936 mg.
Atropine sulfate	0.0362 mg.
Scopolamine hydrobromide	0.0121 mg.

From the Department of Medicine, University of Mississippi School of Medicine, and the Mississippi Allergy Clinic.

Ten patients received one-half or one tablet daily, and 10 others were given three tablets daily. Therapy with Ru-Tuss tablets was continued for one month or less in 32 patients, for more than one month to 12 months in 118 patients, and for more than 12 months in four patients.

A study of 154 patients selected from the clinical practice of allergy was conducted in order to assess the effects of Ru-Tuss tablets in producing symptomatic relief. Seventy patients became symptom-free, and marked improvement occurred in 62. Eleven patients had a fair response and 11 others a poor response. The author discusses the study and the side effects reported from use of the preparation.

A variety of other medications were continued when therapy with Ru-Tuss tablets was initiated. Desensitization procedures were also employed concurrently in some patients.

The overall symptomatic response was classified in each case on the basis of the following criteria:

Excellent	complete relief of symptoms
Good	marked improvement
Fair	slight improvement
Poor	no improvement

Information relative to side effects was carefully sought and recorded during the course of the study.

On the basis of the criteria outlined above there was an excellent symptomatic response in 70 patients (45 per cent). The response was good in 62 patients (40 per cent), fair in 11 (7 per cent), and poor in 11 patients (7 per cent). Thus, a clinically significant response (excellent or good)

was seen in 132 of 154 patients (85 per cent).

Similar results were produced in all types of allergic disorders. The relationship between the clinical condition and the response is shown in Table 1.

The percentage of patients showing an excellent or good response ranged from 72 in seven patients with post nasal drip to 91 in 101 patients with allergic rhinitis.

The effects of Ru-Tuss tablets were also compared with those of previous medications in 130 patients. In 114 cases (88 per cent) Ru-Tuss tablets produced a better response. In 13 patients there was no detectable difference. In three instances Ru-Tuss tablets were less effective than previous medications.

CONCURRENT MEDICATION

In 143 patients the response could be compared to concurrently administered drugs. Ru-Tuss tablets were more effective than the concurrent medication in 32 patients (22 per cent). There was no detectable difference in 99 cases. Ru-Tuss tablets appeared to be less effective in 12 patients.

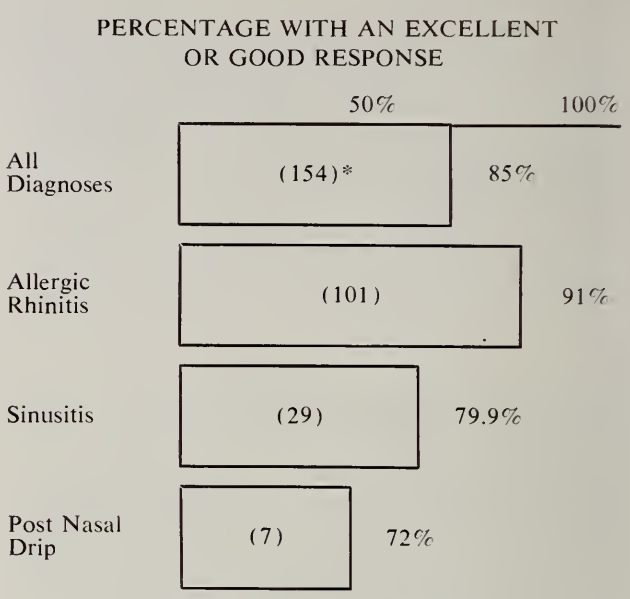
Side effects were limited almost entirely to patients failing to show a pronounced therapeutic response. Only 2 of 70 patients with an excellent response experienced side effects—a slight dryness of the mouth and mild sedation. Two patients who had a good response complained of insomnia; three reported dryness of the mouth; two noted blurring of vision; and "flushing" occurred in two. The drug was discontinued in two of these patients. Six of 11 patients who had a poor response complained of side effects of the antihistamine type. Ru-Tuss tablets were discontinued in all six. Most of these patients had also tolerated other preparations poorly.

TABLE 1

A COMPARISON BETWEEN THE CLINICAL CONDITION AND THE RESPONSE

Clinical Condition	*Response* EXCELLENT	GOOD	FAIR	POOR
Perennial and Seasonal Allergic Rhinitis	47	44	3	7
Sinusitis	10	13	3	3
Post Nasal Drip	3	2	1	1
Asthma	1	1	1	0
Bronchitis	1	1	1	0
Food Allergy	0	0	1	0
Rhinitis Medicamentosa	3	1	0	0
Upper Respiratory Infection	3	0	0	0
Vertigo	1	0	0	0
Allergic Conjunctivitis	1	0	0	0
Otitis Media	0	0	1	0
Totals	70	62	11	11

For graphic purposes the number of patients showing an excellent or good response in several of these diagnostic categories was converted to a percentage for presentation in Figure 1.



* The total number of patients in each group.

Figure 1

The symptomatic management of allergic upper respiratory disorders commonly involves more than one therapeutic approach. In our series, desensitization, antihistamines, antibiotics, and allergen avoidance programs were frequently employed concurrently. Ru-Tuss tablets were significantly more effective than concurrent medications in 32 of 143 patients (22 per cent). The difficulties encountered in evaluating the effects of concurrently administered medications are reflected in the fact that no difference was detectable in 99 patients (69 per cent).

DEMONSTRATION OF EFFICACY

The superiority of Ru-Tuss tablets was more clearly demonstrated in the comparison with previous medications. Ru-Tuss tablets produced a better response in 114 of 130 patients (88 per cent). Since the same criteria were used to evaluate both the previous medication and Ru-Tuss tablets, we could assign numerical values to each of the responses as follows:

Excellent	4
Good	3
Fair	2
Poor	1

The average score on Ru-Tuss tablets was 3.2. On previous medications the average score was 1.8. Thus, it is evident that the response to Ru-Tuss tablets was significantly better than the response to a variety of previously used medications in a large percentage of patients.

On the basis of the results obtained in this study, it is concluded that Ru-Tuss tablets are of significant clinical value in the symptomatic management of upper respiratory allergic disorders. It is highly effective and side effects are infrequent.

SUMMARY

One hundred and fifty-four patients were selected from the clinical practice of allergy to assess the effects of Ru-Tuss tablets in producing symptomatic relief. Perennial and seasonal allergic rhinitis, sinusitis, and post nasal drip were the most common clinical conditions. The usual dose consisted of one prolonged-action tablet morning and evening. Therapy was continued for one month or less in 32 patients, for one month to a year in 118 patients, and for more than one year in four patients. Other medications were employed concurrently.

Seventy patients became symptom-free, and marked improvement occurred in 62. Eleven patients had a fair response and 11 others a poor response. The percentage of patients showing an excellent or good response was similar in all of the conditions treated and ranged from 72 per cent (post nasal drip) to 91 per cent (allergic rhinitis). Comparison of response to Ru-Tuss tablets and previous medications showed Ru-Tuss tablets to be more effective in 88 per cent of the patients. Side effects were reported by 17 patients, and the drug was discontinued in eight. These patients also tolerated other preparations poorly.

On the basis of these results it is concluded that Ru-Tuss tablets are of value in the symptomatic management of upper respiratory allergic disorders. ★★★

2500 N. State St. (39216)

RU-TUSS tablets used in this investigation were supplied by Rocker Pharmacal Co., Inc., Shreveport, La.

NAKED TRUTH

Sign in the operations center at Chicago's Meigs Field, a favorite for private aviation in the Windy City: "Absolutely no flying is permitted over the nudist colony 11.4 miles NNW of the field on a true course of 301 degrees."

Radiologic Seminar LXXII: Rectal Hemangioma

NANCY BURROW, M.D.
Jackson, Mississippi

BENIGN INTESTINAL hemangiomata are rare and may or may not be associated with similar tumors of the skin. They may be single or multiple. Preoperative recognition of these lesions is important because they may be fatal if not surgically treated. The small bowel is the most common site of occurrence; rectum and colon are less common; and stomach and esophageal occurrences are extremely rare.

Hemangiomata are commonly grouped into capillary and cavernous types with admixtures of both. Capillary hemangiomata occurring singly may be conceived more properly as hamartomas. Cavernous hemangiomata composed of larger, irregular blood-filled spaces are often multiple and vary from small polypoid lesions to large, diffuse, expansive tumors.

Hemangiomata arise in the submucosa of the intestine, grow intramurally, ulcerate, hemorrhage and may cause intestinal obstruction by intussusception when polypoid. Intestinal hemorrhage is the most common symptom, occurring in two-thirds of the cases. The ideal treatment is excision or cautery.

X-ray diagnosis, in the face of GI bleeding, should be made after demonstration of mucosal filling defects and the presence of calcific densities representing phleboliths.

CASE REPORT

A 27-year-old female presented with a history of rectal bleeding for many years, with increasing frequency and amounts. The bleeding consisted of bright red blood and was associated with normal stools.



Figure 1. Arrows indicate pressure defect on left aspect of rectoanal region. Note numerous phleboliths in the area.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Hinds General Hospital.

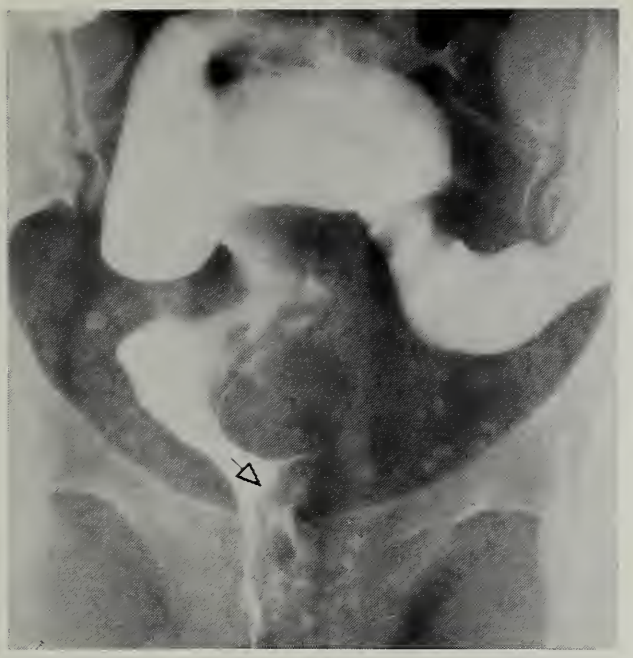


Figure 2. Pressure defect is again noted by arrow.

Barium enema showed a large pressure defect mainly on the left posterior and lateral margin of the rectum. The mass contained numerous calcifications of a characteristic phlebolith appearance and extended into the pelvis and presacral space.

On rectal examination, the mass was found to involve the entire circumference of the rectum and was soft and compressible. The mucosa in the rectal area was thickened and discolored to approximately 20 cm. above the anorectal line and a small ulcerated area was noted in the anterior anal region.

A diagnosis of rectal hemangioma was made and subsequently an abdominoperineal with a pull-through procedure was performed with good results. ★★★

1850 Chadwick Dr. (39204)

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2. Bockus, H. L.: Gastroenterology, Philadelphia, W. B. Saunders Company, 1964, vol. 2, p. 983.
3. Feldman, Maurice: Clinical Roentgenology of the Digestive Tract, Baltimore, Williams and Wilkins Company, 1946, p. 471.
4. Kerekes, E. S.: Gastric Hemangioma, Radiology 82:468-69, 1964.
5. Marine, Robert: Cavernous Hemangioma of the Gastrointestinal Tract, Radiology 70:860-863, 1958.
6. Nys, A., and Buyssens, N.: Diffuse Cavernous Hemangiomatosis, Gastroenterology 45:663-666.
7. Purzanski, W.: Intestinal and Cutaneous Hemangiomatosis, Am. J. Digest. Dis. 8:200-205.

INFERIOR LINEMAN

The line coach pointed out an upcoming sophomore tackle to the head coach during spring practice. "What do you think of Jones, boss?" he asked.

Mournfully, the head mentor replied: "Oh, he's as big as a gorilla, and he is as strong as a gorilla. Boy, if he could only *think* like a gorilla!

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 16-20, 1968, San Francisco, Calif.; Clinical Convention, Dec. 1-4, 1968, Miami Beach, Fla. F. J. L. Blasingame, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

American Academy of General Practice, Annual Meeting, Sept. 13-20, 1968, Las Vegas, Nev. Mr. Mac F. Cahal, Executive Director, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

Southern Medical Association, Annual Meeting, Nov. 18-21, 1968, New Orleans, La. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 100th Annual Session, May 13-16, 1968, Jackson. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. S. E. Field, Jr., Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. William O. Barnett, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 668, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday Quarterly, Jefferson Davis Memorial Hospital, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Second Wednesday March, June, September, and December. Herbert R. Power, Vaiden Clinic, Vaiden, P.O. Box 85.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, M. Beckett Howorth, Jr., 2200 S. Lamar Blvd., Oxford, Secretary.

Pearl River County Medical Society, Second Monday every month. J. M. Howell, 215 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, P.O. Box 1230, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, 1513 Clay Street, Vicksburg, Secretary.

100th Annual Session

Mississippi State Medical Association
May 13-16, 1968
Jackson

THE MEDICAL SPOTLIGHT focuses on Jackson May 13-16 with the convening of the 100th Annual Session. Six general sessions, nearly a dozen specialty societies and related groups, four medical alumni occasions, and a notable first in medical color television will be compressed into the four day meet. Headquarters will be the Hotel Heidelberg where scientific meetings, exhibits, and sessions of the House of Delegates will be held.

Dr. Temple Ainsworth of Jackson, association president, will address the opening meeting of the House of Delegates on Monday, May 13. The principal guest speaker will be Dr. Dwight L. Wilbur of San Francisco, president-elect of the American Medical Association. House Speaker William E. Lotterhos and Vice Speaker James L. Royals, both of Jackson, said that reports and resolutions will be presented at the opening meeting, also. Final actions will come on Thursday, May 16, together with election of 1968-69 officers, Trustees, and council members.

At the adjourned meeting of the House of Delegates, Dr. Joseph B. Rogers of Oxford will be inaugurated 1968-69 president. Dr. Walter H. Simmons of Jackson said that the Scientific Assembly will meet on Tuesday, Wednesday, and Thursday morning. Dr. Simmons is chairman of the group which plans, organizes, and programs the annual session. Medical color television, originating at the University Medical Center for closed-circuit reception in the Heidelberg Olympic Room, will be seen during each of the three days.

The Woman's Auxiliary will conduct its 45th Annual Session concurrently with the association, according to Mrs. David L. Clippinger of Hazlehurst, president of the ladies' group. The Auxiliary will name a president-elect and a president for 1968-69. Mrs. Raymond S. Martin, Jr., is general chairman, and Mrs. Howard H. Nichols is co-chairman. Both are from Jackson.

Medical alumni from Ole Miss, Tennessee, Tulane, and Vanderbilt plan social occasions. The annual association social event will be a "Roaring Twenties" party on Wednesday evening.

Technical and scientific exhibits will be in the Heidelberg Victory Room and adjacent areas, and all general scientific sessions are slated for the Olympic Room.

OFFICIAL CALL

To all members of the Mississippi State Medical Association

The 100th Annual Session of the Mississippi State Medical Association is called to meet at Jackson, Mississippi, on Monday, May 13, 1968, pursuant to Article V of the constitution. The House of Delegates will be convened at 9 o'clock in the morning at the Hotel Heidelberg.

The Scientific Assembly, consisting of the general sessions, will meet during the period May 14-16, 1968.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

TEMPLE AINSWORTH
PRESIDENT

WALTER H. SIMMONS
SECRETARY-TREASURER

The Heidelberg is accepting reservations, association spokesmen said, and members are urged to communicate early with the hotel. Other nearby hotels are the new Downtowner and the Sun 'N Sand. Because of the anticipated large attendance, the headquarters hotel, where there are now no suites available, will be unable to accommodate the entire out-of-Jackson registration.

STATE OFFICERS 1967-68



Dr. Ainsworth

President
Temple Ainsworth, M.D.
Jackson

President-Elect
Joseph B. Rogers, M.D.
Oxford

Secretary-Treasurer
Walter H. Simmons, M.D.
Jackson



Dr. Rogers

Vice Presidents	Ashford H. Little, M.D., Oxford C. G. Sutherland, M.D., Jackson Richard J. Field, Jr., M.D., Centreville
Editor	W. Moncure Dabney, M.D., Crystal Springs
Associate Editors	George H. Martin, M.D., Vicksburg Thomas W. Wesson, M.D., Tupelo
Speaker	William E. Lotterhos, M.D., Jackson
Vice Speaker	James L. Royals, M.D., Jackson
AMA Delegates	J. P. Culpepper, Jr., M.D., Hattiesburg Howard A. Nelson, M.D., Greenwood G. Swink Hicks, M.D., Natchez
Executive Secretary	Rowland B. Kennedy, Jackson
Assistant Executive Secretary	Charles L. Mathews, Jackson

THE BOARD OF TRUSTEES

John B. Howell, Jr., M.D., Canton, Chairman

Lamar Arrington, M.D., Meridian, Vice Chairman

C. D. Taylor, Jr., M.D., Pass Christian, Secretary

John M. Alford, Jr., M.D., Greenwood

James O. Gilmore, M.D., Oxford

J. T. Davis, M.D., Corinth

Mal S. Riddell, Jr., M.D., Winona

W. E. Moak, M.D., Richton

Everett Crawford, M.D., Tylertown

LIVING PAST PRESIDENTS

1940-1941 William H. Anderson, M.D., Booneville

1941-1942 A. Street, M.D., Vicksburg

1943-1944 E. Leroy Wilkins, M.D., Clarksdale

1948-1949 R. B. Caldwell, M.D., Baldwyn

1949-1950 B. B. O'Mara, M.D., Biloxi

1950-1951 B. S. Guyton, M.D., Oxford

1951-1952 James Grant Thompson, M.D., Jackson

1952-1953 Lamar Arrington, M.D., Meridian

1955-1956 S. Lamar Bailey, M.D., Kosciusko

1956-1957 H. C. Ricks, M.D., Jackson

1957-1958 Howard A. Nelson, M.D., Greenwood

1958-1959 Guy T. Vise, M.D., Meridian

1959-1960 Stanley A. Hill, M.D., Corinth

1960-1961 G. Swink Hicks, M.D., Natchez

1961-1962 Lawrence W. Long, M.D., Jackson

1962-1963 C. P. Crenshaw, M.D., Collins

1964-1965 Omar Simmons, M.D., Newton

1965-1966 Everett Crawford, M.D., Tylertown

1967-1968 James T. Thompson, M.D., Moss Point

ACTIVITIES CALENDAR

REGISTRATION

General registration for the Scientific Assembly and House of Delegates will be located on the Second Floor Lobby, the Heidelberg. No person will be admitted to any activity of the Annual Session without first registering. The Secretary's Office will also be located on the Second Floor. Hours of registration will be 8:00 a.m. to 5:00 p.m. Monday through Wednesday and 8:00 a.m. to 2:00 p.m. Thursday.

SUNDAY, MAY 12, 1968

1:00 p.m. Miss. Association of Pathologists, Silver Room

6:30 p.m. Miss. Society of Anesthesiologists, Jackson County Club

MONDAY, MAY 13, 1968

9:00 a.m. Miss. Orthopaedic Society, University Medical Center

9:00 a.m. House of Delegates, Rose Room

9:00 a.m. Miss. Association of Pathologists, Parlor A

12:00 noon American College of Surgeons Luncheon, Silver Room

12:00 noon Miss. Orthopaedic Society Luncheon, Primos' Northgate Restaurant

2:00 p.m. Miss. Urological Association, Parlor B

2:00 p.m. Reference Committee on Reports of Officers and Board of Trustees, Rose Room

3:30 p.m. Reference Committee on Miscellaneous Business, Parlor A

4:00 p.m. Council on Constitution and By-Laws, Secretary's Office

4:00 p.m. Reference Committee on Medical Practices, Silver Room

5:00 p.m. Vanderbilt University Medical Alumni, Parlors A and B

6:00 p.m. Tulane Medical Alumni, Silver Room

6:30 p.m. University of Tennessee Medical Alumni, Heidelberg Roof

TUESDAY, MAY 14, 1968

8:00 a.m. Woman's Auxiliary Pre-Convention Executive Board Breakfast, Silver Room

9:00 a.m. General Scientific Session, Olympic Room

11:30 a.m. Woman's Auxiliary Luncheon, Jackson Country Club

12:00 noon Fifty Year Club Luncheon, Parlor A

12:00 noon Flying Physicians Association Luncheon, Rose Room

12:00 noon Miss. Ob-Gyn Society Luncheon, Silver Room

2:00 p.m. General Scientific Session, Olympic Room

4:00 p.m. University of Mississippi Medical Alumni, Silver Room

6:00 p.m. Miss. Radiological Society Dinner, Sun n Sand

7:00 p.m. University of Mississippi Medical Alumni, Olympic Room

WEDNESDAY, MAY 15, 1968

7:30 a.m. Past Presidents' Breakfast, MSMA, Parlor A

8:30 a.m. General Scientific Session, Olympic Room

9:00 a.m. Woman's Auxiliary General Session, Rose Room

12:00 noon Miss. Psychiatric Society Luncheon, Parlor B

12:00 noon Miss. Society of Internal Medicine Luncheon, Silver Room

2:00 p.m. General Scientific Session, Olympic Room

2:30 p.m. Woman's Auxiliary Post-Convention Executive Board Meeting, Rose Room

2:30 p.m. Nominating Committee, MSMA, Silver Room

7:00 p.m. MSMA Roaring 20's Party, Olympic Room

THURSDAY, MAY 16, 1968

8:00 a.m. Woman's Auxiliary Past Presidents' Breakfast, Parlor A

9:30 a.m. General Session on Pediatrics, Olympic Room

9:30 a.m. General Session on Eye, Ear, Nose, and Throat, Silver Room

1:30 p.m. House of Delegates, Rose and Silver Rooms

4:00 p.m. Diabetes Association of Mississippi, Parlor B

EXECUTIVE BUSINESS



DR. LOTTERHOS

HOUSE OF DELEGATES

Monday, May 13, 1968
9:00 a.m.

Heidelberg Hotel
Rose Room

William E. Lotterhos
Jackson, Speaker

James L. Royals
Jackson, Vice Speaker



DR. ROYALS

MEETINGS OF THE HOUSE

The meeting will be opened by the President, and the Speaker, in presiding over the House, will announce the order of business. An open session, Monday, May 13, 1968, to which all members and Auxiliary members are invited will feature the Address of the President, Dr. Temple Ainsworth, and a special address by Dr. Dwight L. Wilbur, President-elect of the American Medical Association. The adjourned meeting of the House will convene in the Rose Room at 1:30 p.m. on Thursday, May 16.

REFERENCE COMMITTEES

Reports of Officers and Board of Trustees, Monday, May 13, Rose Room, 2:00 p.m.

Medical Practices, Monday, May 13, Silver Room, 4:00 p.m.

Constitution and By-Laws, Monday, May 13, Secretary's Office, 4:00 p.m.

Miscellaneous Business, Monday, May 13, Parlor A, 3:30 p.m.

Nominating Committee, Wednesday, May 15, Silver Room, 2:30 p.m.

THE SCIENTIFIC ASSEMBLY



Dr. Simmons

COUNCIL ON SCIENTIFIC ASSEMBLY

Walter H. Simmons, M.D., Chairman

THE COUNCIL

John E. Green, Chairman, EENT
(Emmett M. Herring, Jr., Secretary)

Charles R. Jenkins, Chairman, General Practice
(Hardy B. Woodbridge, Jr., Secretary)

William C. Kellum, M.D., Chairman, Medicine
(C. Ralph Daniel, Jr., Secretary)

John E. Lindley, Chairman, Ob-Gyn
(J. Purves McLaurin, Jr., Secretary)

Charles P. Tharp, Chairman, Pediatrics
(William F. Sistrunk, Secretary)

Rhea L. Wyatt, Chairman, Preventive Medicine
(Frank J. Morgan, Jr., Secretary)

Raymond S. Martin, Chairman, Surgery
(Carl D. Brannan, Secretary)

MEDICAL COLOR TELEVISION

William O. Barnett, Chairman

MEDICAL MOTION PICTURES

Calvin T. Hull, Chairman

SCIENTIFIC AND TECHNICAL EXHIBITS

Hotel Heidelberg

CONDUCT OF THE SCIENTIFIC ASSEMBLY

The order of exercise, papers, and discussions as set forth in the official program shall be followed until completion. All papers read before the association shall become its property. Each paper must be read by its author and deposited with the Secretary (or Chairman) when read.

THE SCIENTIFIC EXHIBIT

Physicians, foundations, and organizations will present the Scientific Exhibit. Physician-members of the Mississippi State Medical Association are eligible for the Aesculapius Award, given for excellence of presentation, quality of content, and originality. This award, a permanent plaque, also offers an honorarium of $200 and is presented as a joint project of the association and the Mead Johnson Laboratories. Non-member, out-of-state physician exhibitors compete for the association's Scientific Achievement Award. The Scientific Exhibit is located in the Heidelberg Hotel.

EXHIBITORS

"Some Causes of Blackout Spell—With Emphasis on Cerebrovascular Insufficiency"
James D. Hardy, M.D.; Hilary H. Timmis, M.D.; Dov Weissburg, M.D.; and Pandeli Anas, M.D., Jackson

"The Mississippi Artificial Kidney Program"
John D. Bower, M.D., Jackson

"Arthritis of the Hand"
J. T. Davis, M.D., Corinth

"Vascular Disorders of the Central Nervous System"
Robert R. Smith, M.D., and Armin F. Haerer, M.D., Jackson

"Emphysema—Surgical Management"
William R. Fain, M.D.; J. Harold Conn, M.D.; Guy D. Campbell, M.D.; Carlos M. Chavez, M.D.; Happy L. Gee, M.D.; and James D. Hardy, M.D., Jackson

"Surgical Management of Valvular Heart Disease"
Hilary H. Timmis, M.D., and James D. Hardy, M.D., Jackson

"Important Anatomical Factors in Cholorcystectomy"
W. O. Barnett, M.D., and Edward M. Lowicki, M.D., Jackson

"Occlusive Lesions of the Abdominal Aorta and Its Branches"
Thomas L. Kilgore, Jr., M.D.; J. Harvey Johnston, Jr., M.D.; George E. Twente, M.D.; W. Coupery Shands, M.D.; and James C. Griffin, Jr., M.D., Jackson

"Unusual Thoracic Surgical Problems in Children"
Edward S. Lindsey, M.D., New Orleans, Louisiana

"Myocardial Revascularization"
Charles W. Pearce, M.D., and Albert L. Hyman, M.D., New Orleans, Louisiana

"Open Heart Surgery for Congenital Defects"
Charles W. Pearce, M.D., and James L. Reynolds, M.D., New Orleans, Louisiana

"Minor Surgical Correction of the Cicatricial Alopecias"
D. B. Stough, III, M.D., Hot Springs, Arkansas

"Diet and Its Relation to Heart Disease"
Mississippi Heart Association, Jackson

"Arthritis—Care Today and Cure Tomorrow"
The Arthritis Foundation, Jackson

"The Mississippi Regional Medical Program"
University Medical Center, Jackson

"Reach to Recovery"
St. Dominic Hospital, Jackson

MEDICAL MOTION PICTURES

As an extension of the program of the Scientific Assembly, selected medical motion pictures will be shown in conjunction with general sessions. The schedule follows:

Tuesday, May 14

7:30 a.m. Olympic Room
"The Problem of Early Diagnosis of Breast Cancer"
"Management of Surgical Complications"

1:00 p.m. Olympic Room
"Resuscitation of the Newborn"
"Breach Delivery"

Wednesday, May 15

7:15 a.m. Olympic Room
"Miracle of Dialysis"
"Chronic Bronchitis—A Team Affair"

1:00 p.m. Olympic Room
"Cinegastroscopy with the Fiberscope—An Aid to Diagnosis of Gastric Lesions"
"Coronary Occlusion"

Thursday, May 16

8:00 a.m. Olympic Room
"The Neurological Examination of the Newborn"
"Otitis Media in Pediatrics"

8:00 a.m. Silver Room
"Roundpupil Intracapsular Cataract Extractions"
"Physical Diagnosis of the Ear, Nose and Throat"

THE TECHNICAL EXHIBIT

The Mississippi State Medical Association presents with pride the 1968 Technical Exhibit. Established firms engaged in the manufacture and distribution of pharmaceuticals, supplies, equipment, and in providing varied services will present exhibits. Visit each exhibit often and discuss products and services with the Professional Service Representatives. Only registered members and guests are admitted. The Technical Exhibit is located in the Victory Room, Heidelberg Hotel.

EXHIBITORS	BOOTH
Abbott Laboratories, North Chicago, Ill.	8
Airkem-Mississippi, Inc.	21
Atlas Chemical Industries, Inc., Pasadena, Calif.	2
Ayerst Laboratories, New York, N. Y.	1
Bentex Pharmaceutical Co., Houston, Texas	39
Ciba Pharmaceutical Products, Inc., Summit, N. J.	23
Coca-Cola Company, Atlanta, Ga.	14
The EMKO Company, St. Louis, Mo.	37
Geigy Pharmaceuticals, Yonkers, N. Y.	13
Kay Surgical, Inc., Jackson, Miss.	4
Lanier Company, Jackson, Miss.	49
Mallinckrodt Pharmaceuticals, St. Louis, Mo.	5
3M Business Products Sales, Inc., Jackson, Miss.	6
McNees Medical Supply Co., Jackson, Miss.	11
Mead Johnson Laboratories, Evansville, Ind.	22
Merck Sharp and Dohme, Philadelphia, Pa.	7
Merrill Lynch, Pierce, Fenner and Smith, Inc., Jackson, Miss.	25
Mississippi Hospital and Medical Service, Jackson, Miss.	15
Mutual Benefit Life Insurance Co., Newark, N. J.	12

Ortho Pharmaceutical Corporation, Raritan, N. J. 33
Parke, Davis and Company, Detroit, Mich. 32
Pepsi-Cola Bottling Association, Meridian, Miss. 35
William P. Poythress and Co., Richmond, Va. 18
A. H. Robins Company, Richmond, Va. 3
William H. Rorer, Inc., Fort Washington, Pa. 42
Sandoz Pharmaceuticals, Hanover, N. J. 40
W. B. Saunders Company, Philadelphia, Pa. 28
Schering Corporation, Union, N. J. 19
G. D. Searle and Company, Chicago, Ill. 38
Smith Kline and French Laboratories, Philadelphia, Pa. 10
Smith, Miller and Patch, Inc., New York, N. Y. 27
Southern Surgical Supply Co., Inc., New Orleans, La. 17
Syntex Laboratories, Palo Alto, Calif. 9
Travelers Insurance Co., Jackson, Miss. 50
Wildlife Recreation Club, Inc., Memphis, Tenn. 44
Winthrop Laboratories, New York, N. Y. 41

SCIENTIFIC GRANTS

Eli Lilly and Company, Indianapolis, Ind.

S. E. Massengill Company, Bristol, Tenn.

Upjohn Company, Kalamazoo, Mich.

REGISTRATION FOR EXHIBIT PRIZES

Visit the Technical Exhibits often and qualify for the drawing of attractive prizes. Obtain necessary initials as you visit each booth. Deposit cards at Registration not later than 12:30 p.m., Thursday, May 16.

SCIENTIFIC PROGRAM



DR. MARTIN

Tuesday, May 14, 1968
Olympic Room
Beginning at 9:00 a.m.

Raymond S. Martin, Jr., Jackson
Chairman

Carl D. Brannan, Jackson
Secretary

MEDICAL COLOR TELEVISION—SURGERY OF THE BREAST

J. Harvey Johnston, Jr., Jackson
Moderator
Curtis P. Artz, Charleston, South Carolina
Richard J. Field, Jr., Centreville
Elmer J. Harris, Jackson
William L. Thornton, Meridian
James D. Hardy, Jackson, Operating Surgeon

REACH TO RECOVERY

Mrs. Terese Lasser, New York

SCIENTIFIC PROGRAM



DR. LINDLEY

Tuesday, May 14, 1968
Olympic Room
Beginning at 2:00 p.m.

John E. Lindley, Meridian
Chairman

J. Purves McLaurin, Jr., Oxford
Secretary

MEDICAL COLOR TELEVISION

PART I—AMNIOCENTESIS AND THE RH PROBLEM

PART II—CESAREAN SECTION

James L. Royals, Jackson
Moderator
Warren N. Bell, Jackson
Leonard W. Fabian, Jackson
Daniel H. Draughn, Jackson
Winfred L. Wiser, Jackson
John W. Choate, Jackson
Henry A. Thiede, Jackson, Operating Surgeon

ESSAYS, Olympic Room Rostrum

ERRORS IN THE USE OF THE PAP SMEAR
Robert R. Hughes, Memphis

SHOCK, STILL A PROBLEM—NEWER CONCEPTS
William A. Neely, Jackson

SCIENTIFIC PROGRAM



Dr. Jenkins

Wednesday, May 15, 1968
Olympic Room
Beginning at 8:30 a.m.

Charles R. Jenkins, Laurel
Chairman

Hardy B. Woodbridge, Jr., Jackson
Secretary

Medical Color Television—Lesions and Conditions of the Skin
James Grant Thompson, Jackson
Moderator

J. A. Brown, Jr., Jackson
Charles W. Caccamise, Jackson
John G. Forshner, Jackson
Louis J. Wise, Jackson

Essay, Olympic Room Rostrum
Amenorrhea
John C. Weed, New Orleans

SCIENTIFIC PROGRAM



Dr. Wyatt

Wednesday, May 15, 1968
Olympic Room
Beginning at 10:15 a.m.

Rhea L. Wyatt, Holly Springs
Chairman

Frank J. Morgan, Jr., Jackson
Secretary

Panel, Olympic Room Rostrum
The Delta Pilot Project
Herbert A. Hudgins, Atlanta
Moderator

James L. Kurowski, Greenville
Albert L. Ball, Indianola
Jordan J. Antonelli, Winona
Alfio Rausa, Greenwood

Medical Color Television—Lumps and Activity of the Thyroid
Herbert G. Langford, Jackson
Moderator
Joseph L. Glasgow, Jackson
George H. Martin, Vicksburg

SCIENTIFIC PROGRAM



DR. KELLUM

Wednesday, May 15, 1968
Olympic Room
Beginning at 2:00 p.m.

William C. Kellum, Tupelo
Chairman

C. Ralph Daniel, Jr., Jackson
Secretary

MEDICAL COLOR TELEVISION—NEUROLOGY CLINIC
Robert D. Currier, Jackson
Moderator
Charles L. Neill, Jr., Jackson

ESSAYS, Olympic Room Rostrum
ROENTGEN EXAMINATION OF THE SMALL BOWEL
Charles M. Nice, Jr., New Orleans

ULCERATIVE COLITIS—DIAGNOSIS AND MANAGEMENT
William D. Davis, Jr., New Orleans

A CONSIDERATION OF THE MEDICAL POST-GASTRECTOMY
E. Leonard Posey, Jr., Jackson

SCIENTIFIC PROGRAM



DR. THARP

Thursday, May 16, 1968
Olympic Room
Beginning at 9:30 a.m.

Charles P. Tharp, Tupelo
Chairman

William F. Sistrunk, Jackson
Secretary

MEDICAL COLOR TELEVISION—PEDIATRIC MUSCULO-SKELETAL ABNORMALITIES
George D. Purvis, Jackson
Moderator

Thomas H. Blake, Jackson
Paul Derian, Jackson
Howard H. Nichols, Jackson
James M. Packer, Jackson
William B. Wiener, Jackson

ESSAY, Olympic Room Rostrum
MANAGEMENT OF STEROID-RESISTANT NEPHROTIC SYNDROME
James N. Etteldorf, Memphis

SCIENTIFIC PROGRAM



DR. GREEN

Thursday, May 16, 1968
Silver Room
Beginning at 9:30 a.m.

John E. Green, Hattiesburg
Chairman

Emmett M. Herring, Jr., Hattiesburg
Secretary

CEREBRAL DISFUNCTION—ITS RELATION TO EENT
J. G. Jabour, Memphis

EPIBULBAR SQUAMOUS CELL CARCINOMA
John C. Suares, Greenville

ROARING 20's PARTY

Nickle beer is back at MSMA's big Roaring 20's Party to the tune of the Charleston as presented by the Gaslight Club Road Show of Chicago. "Greasy Thumb" Ainsworth and the South Side Board from "Big Chi" led by "The Enforcer," alias John B. Howell, will get things underway at 7:00 p.m. in the Olympic Room, the Heidelberg Hotel. Just check your violin case, knock, and say "Temple sent me." Tickets are available under the counter at registration.

GOLF TOURNAMENT

The annual association golf tournament will be conducted at the Jackson Country Club, Wednesday, May 15. Dr. Dewitt T. Brock, Jr., of Jackson is chairman. The $10 entrance fee includes one green fee and the tournament fellowship hour, 5 to 6 p.m. Advance registration is provided for and entrants may also play on Tuesday, but the entrance fee covers green fees for one day only.

VISITING ESSAYISTS



Dr. Davis

William D. Davis, Jr., M.D., New Orleans, Louisiana. Chief, Department of Gastroenterology, Ochsner Clinic. Medical Education: Tulane University, 1943. Diplomate, American Board of Internal Medicine.

James N. Etteldorf, M.D., Memphis, Tennessee. Professor of Pediatrics, University of Tennessee College of Medicine. Medical Education: University of Tennessee College of Medicine, 1942. Diplomate, American Board of Pediatrics.



Dr. Etteldorf



Dr. Hudgins

Herbert A. Hudgins, M.D., Atlanta, Georgia. Associate Regional Health Director, U.S.P.H.S., Region IV. Medical Education: Emory University, 1936. Diplomate, American Board of Preventive Medicine.

Robert R. Hughes, M.D., Memphis, Tennessee. Associate Professor of Ob-Gyn, University of Tennessee College of Medicine. Medical Education: University of Tennessee College of Medicine, 1952. Diplomate, American Board of Ob-Gyn.



Dr. Hughes

VISITING ESSAYISTS

J. T. JABBOUR, M.D., Memphis, Tennessee. Assistant Professor of Pediatric Neurology, University of Tennessee College of Medicine. Medical Education: University of Tennessee College of Medicine, 1951. Diplomate, American Board of Pediatrics.



DR. JABBOUR



DR. NICE

CHARLES M. NICE, JR., New Orleans, Louisiana. Chairman, Department of Radiology, Tulane University School of Medicine. Medical Education: University of Kansas School of Medicine, 1943. Diplomate, American Board of Radiology.

JOHN C. WEEK, M.D., New Orleans, Louisiana. Instructor in Gynecology, Tulane University School of Medicine. Medical Education: Tulane University School of Medicine, 1936. Diplomate, American Board of Ob-Gyn.



DR. WEEK



DR. WILBUR

DWIGHT L. WILBUR, M.D., San Francisco, California. President-elect, American Medical Association. Medical Education: University of Pennsylvania School of Medicine. Diplomate, American Board of Internal Medicine.

WOMAN'S AUXILIARY TO THE MISSISSIPPI STATE MEDICAL ASSOCIATION

45th Annual Session
Heidelberg Hotel
May 13-16, 1968

Mrs. D. L. Clippinger
Hazelhurst
President



Mrs. Clippinger

ANNUAL SESSION CHAIRMEN

Mrs. Raymond S. Martin
Jackson
General Chairman

Mrs. Howard H. Nichols
Jackson
Co-Chairman

Mrs. L. Ben McCarty
Jackson
Luncheon

Mrs. W. B. Wiener
Jackson
Transportation

Mrs. Cecil G. Jenkins
Jackson
Registration

Mrs. H. Richard Johnson
Jackson
Decorations

Mrs. Joseph B. Miller
Jackson
Publicity

Mrs. W. Johnson Witt
Jackson
Style Show

AUXILIARY

Monday, May 13, 1968

2:00 p.m. Finance Committee Meeting, Mrs. A. T. Tatum

3:00-5:00 p.m. Registration, Mrs. Cecil G. Jenkins, Chairman
Arcade, Heidelberg Hotel

Tuesday, May 14, 1968

8:00 a.m. Preconvention Executive Board Breakfast
Silver Room, Heidelberg Hotel

8:00-3:00 p.m. Registration
Arcade, Heidelberg Hotel

11:30 a.m. Woman's Auxiliary Luncheon, Jackson Country Club
Mrs. L. Ben McCarty, Chairman
Mrs. D. L. Clippinger, Presiding
THEME: "Painting the True Picture"
Invocation
The Highlanders from Belhaven
Introduction of Guests
Style Show and Luncheon
Guest Speaker
Mrs. R. C. L. Robertson, Houston, Texas
Southern Regional Vice President, Woman's Auxiliary to AMA

1:30 p.m. Sightseeing and Informal Shopping Tour (Transportation to be furnished by your luncheon hostess)

Wednesday, May 15, 1968

8:00 a.m. Continental Breakfast for Auxiliary Members
Rose Room, Heidelberg Hotel

8:00-5:00 p.m. Registration
General Registration, Heidelberg Hotel

9:00 a.m. General Session, Mrs. D. L. Clippinger, Presiding
Rose Room, Heidelberg Hotel
Invocation
Reverend Bill Causey, Jackson
Auxiliary Pledge
Mrs. John G. Egger, Drew
Welcome
Mrs. Raymond F. Grenfell, Jackson
Response
Mrs. Charles C. Thompson, Columbia
Introductions
Greetings from Temple Ainsworth, M.D.
President, MSMA
Greetings from Joseph B. Rogers, M.D.
President-elect, MSMA
Credentials and Registration
Mrs. Raymond S. Martin, Jackson
Roll Call of Voting Delegates
Minutes
President's Report
Mrs. D. L. Clippinger, Hazelhurst
Treasurer's Report
Mrs. David B. Wilson, Jackson

AMA-ERF Report
Mrs. A. E. Brown, Columbus
Finance Report
Mrs. A. T. Tatum, Hattiesburg
Appointment of Delegates to AMA Woman's Auxiliary Meeting
Unfinished Business
New Business
Memorial Service
Mrs. George W. Moss, Natchez

1:30 p.m. Report of Nominating Committee
Mrs. J. Gordon Dees, Jackson
Election of General Officers
Installation of General Officers
Courtesy Resolutions
Mrs. James T. Thompson, Moss Point
Adjournment

2:30 p.m. Postconvention Executive Board Meeting
Rose Room, Heidelberg Hotel

7:00 p.m. MSMA "Roaring 20's" Party
Olympic Room, Heidelberg Hotel

Thursday, May 16, 1968

8:00 a.m. Past Presidents' Breakfast
Mrs. J. Gordon Dees, Presiding
Parlor A, Heidelberg Hotel

MISSISSIPPI SOCIETY OF ANESTHESIOLOGISTS

Mississippi anesthesiologists will meet on Sunday, May 12, at the Jackson Country Club beginning at 6:30 p.m. Dr. Eugene Conner will be the guest speaker. Officers of the society are Drs. Paul A. Roell of Jackson, President; James F. Savage, Jr., of Jackson, President-Elect; and Marion P. Parker of Jackson, Secretary-Treasurer.

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

Members of the Mississippi Association of Pathologists will meet on Sunday and Monday, May 12-13. Activities will begin with a business session at 1:00 p.m., Sunday, May 12, in the Silver Room, Heidelberg Hotel. A scientific session will be conducted on Monday, May 13, beginning at 9:00 a.m. in Parlor A, the Heidelberg Hotel. Officers are Drs. Leo J. Scanlon, Jr., Natchez, President; Kenneth C. Coffelt of Biloxi, President-Elect; and William V. Hare of Jackson, Secretary-Treasurer.

MISSISSIPPI ORTHOPAEDIC SOCIETY

Members of the Mississippi Orthopaedic Society will meet on Monday, May 13, beginning at 9:00 a.m. at the University Medical Center. A luncheon will be held at Primos' Northgate Restaurant. Officers are Drs. John G. Caden of Jackson, President; Paul S. Derian of Jackson, President-Elect; and Thomas C. Turner of Jackson, Secretary-Treasurer.

MISSISSIPPI CHAPTER, AMERICAN COLLEGE OF SURGEONS

Fellows of the Mississippi Chapter, American College of Surgeons will meet for a luncheon and scientific session on Monday, May 13, in the Silver Room, the Heidelberg Hotel at 12:00 noon. A business meeting will precede the luncheon. Officers are Drs. Bedford F. Floyd, Jr., of Gulfport, President; M. Beckett Howorth, Jr., of Oxford, President-Elect; and Dawson B. Conerly, Jr., of Hattiesburg, Secretary-Treasurer.

MISSISSIPPI UROLOGICAL ASSOCIATION

Members of the Mississippi Urological Association will conduct a scientific and business meeting on Monday, May 13, beginning at 2:00 p.m. in Parlor B, Heidelberg Hotel. Officers are Drs. Onnie P. Myers of Jackson, President; and Charles D. Scruggs, of Jackson, Secretary-Treasurer.

FLYING PHYSICIANS ASSOCIATION

Mississippi members of the Flying Physicians Association will meet for a luncheon address by Governor John Bell Williams on Tuesday, May 14, beginning at 12:00 noon in the Rose Room, the Heidelberg Hotel. Non-members are cordially invited to attend this meeting. Officers of the association are Drs. James E. Wadlington of Jackson, President; and Curtis W. Caine of Jackson, Secretary-Treasurer.

TULANE MEDICAL ALUMNI

Tulane University medical alumni will meet for a fellowship hour on Monday, May 13, in the Silver Room, Heidelberg Hotel, beginning at 6:00 p.m.

TENNESSEE MEDICAL ALUMNI

Medical alumni of the University of Tennessee will meet for a fellowship hour and banquet on Monday, May 13 beginning at 6:30 p.m. on the Heidelberg Roof. Dr. Stanley A. Hill of Corinth is program chairman.

VANDERBILT MEDICAL ALUMNI

Medical alumni of the Vanderbilt University School of Medicine will meet on Monday evening May 13, in Parlors A and B, Heidelberg Hotel, for a reunion and fellowship hour beginning at 5:00 p.m. Dr. Thomas M. Blake of Jackson is arrangements chairman and Dr. John L. Shapiro, Chairman, Department of Pathology, Vanderbilt University School of Medicine, will be a special guest.

FIFTY YEAR CLUB

Members of the Mississippi State Medical Association's Fifty Year Club will be honored at a luncheon on Tuesday, May 14, in Parlor A, the Heidelberg Hotel at 12:00 noon. Dr. John B. Howell, Jr., of Canton, Chairman of the Board of Trustees, will preside.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will conduct a luncheon meeting on Tuesday, May 14, at 12:00 noon in the Silver Room, Heidelberg Hotel. Officers of the society are Drs. O. B. Wooley, Jr., of Jackson, President; J. Purves McLaurin, Jr., of Oxford, President-Elect; and Charles M. Head of Jackson, Secretary-Treasurer.

OLE MISS MEDICAL ALUMNI

University of Mississippi medical alumni will meet on Tuesday, May 14. Arrangements for registration at the Heidelberg Hotel have been made by alumni officials. A general business meeting will be conducted at 4:00 p.m. in the Silver Room. The fellowship hour and dinner-dance will be held at 7:00 p.m. in the Olympic Room. Dr. E. E. Ellis of Laurel, presiding. Other officers are Dr. Wendell B. Holmes, McComb, President-Elect, and Mr. Charles W. Price, Jackson, Secretary. Dr. T. E. Wilson, III, of Jackson is Program Chairman. Further details and tickets may be secured from Mr. Price at the University Medical Center, Jackson, or at Ole Miss Registration, the Heidelberg Hotel.

MISSISSIPPI RADIOLOGICAL SOCIETY

The Mississippi Radiological Society will conduct a scientific meeting and dinner on Tuesday evening, May 14, beginning at 6:00 p.m. at the Sun n Sand. Dr. Charles M. Nice, Jr., will be the guest essayist. Officers of the society are Drs. W. L. Rone of Jackson, President; and William M. Flowers, Jr., of Jackson, Secretary-Treasurer. Dr. Otis G. Ball of Jackson is in charge of local arrangements.

MSMA PAST PRESIDENTS' BREAKFAST

Past Presidents of the Mississippi State Medical Association will enjoy a breakfast meeting on Wednesday morning, May 15, at 7:30 a.m. in Parlor A, the Heidelberg Hotel. Dr. James T. Thompson of Moss Point will preside.

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

The Mississippi Society of Internal Medicine will conduct a luncheon on Wednesday, May 15, beginning at 12:00 noon in the Silver Room, the Heidelberg Hotel. Officers of the society are Drs. Raymond F. Grenfell of Jackson, President; Joe S. Covington of Meridian, President-Elect; and Thomas E. Stevens of Jackson, Secretary-Treasurer.

MISSISSIPPI PSYCHIATRIC ASSOCIATION

Members of the Mississippi Psychiatric Association will meet on Wednesday, May 15 at 12:00 noon in Parlor B, the Heidelberg Hotel. Officers are Drs. A. J. Santangelo of Jackson, President; James F. Suess of Jackson, President-Elect; and William J. Erwin of Jackson, Secretary-Treasurer.

DIABETES ASSOCIATION OF MISSISSIPPI

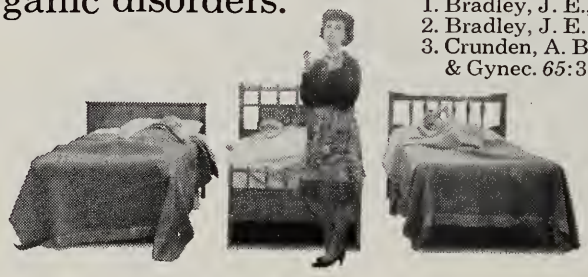
All interested physicians are invited to attend the meeting of the Diabetes Association of Mississippi which will be conducted on Thursday, May 16, in Parlor B, the Heidelberg Hotel, beginning at 4:00 p.m. Officers of the association are Drs. W. J. Huddleston of Hattiesburg, President; J. D. Wofford of Greenwood, President-Elect; and Alton B. Cobb of Jackson, Secretary.



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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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or

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Assistant Professor of Psychiatry and Medical Director
Area Code 704-253-2761

Handbook of the House of Delegates

Mississippi State Medical Association
100th Annual Session, Jackson
May 13-16, 1968

SUPPLEMENTAL REPORT A OF THE SECRETARY-TREASURER

Dr. Walter H. Simmons: Effective May 16, 1968, the following vacancies in office are declared to exist by reason of expiration of terms in accordance with applicable portions of the Constitution and By-Laws. All such vacancies should be filled under the provisions of Chapter VI of the By-Laws which prescribes procedures for election of officers and others:

President-elect

Nominate three, no two of whom may be from the same county, elect one.

Vice Presidents

Nominate three for the Northern Area, three for the Mid-State Area, and three for the Southern Area. Elect one for each area.

Associate Editor

Term 1968-1970. Nominate two, elect one. Incumbent: George H. Martin, Vicksburg.

Delegate to AMA

Term January 1, 1969-December 31, 1970. Nominate two, elect one. Incumbent: Howard A. Nelson, Greenwood.

Alternate Delegate to AMA

Term January 1, 1969-December 31, 1970. Nominate two, elect one. Incumbent: Stanley A. Hill, Corinth.

Board of Trustees, Districts 4, 5, and 6

Terms 1968-1971. Nominate two for each district, elect one for each district. Incumbents: Mal S. Riddell, Jr., Winona, District 4; John B. Howell, Jr., Canton, District 5; and Lamar Arrington, Meridian, District 6. Drs. Howell and Arrington are ineligible for re-election.

To: House of Delegates
Mississippi State Medical Association

The Speaker and Vice Speaker of the House of Delegates herewith present for the information of all members those reports of officers and constitutional bodies of the association in advance of the 100th Annual Session as are ready and approved for publication. It is the intent of this pre-session publication to inform the membership and to afford all concerned opportunity to confer with delegates over any aspect of the reports.

No report herein published becomes official or a statement of policy until formally presented to the House of Delegates and acted upon at the annual session.

WILLIAM E. LOTTERHOS
SPEAKER

JAMES L. ROYALS
VICE SPEAKER

Council on Budget and Finance

Term 1968-1971. Nominate two, elect one. Incumbent: J. T. Davis, Corinth.

Council on Medical Education

Term 1968-1971. Nominate two, elect one. Incumbent: William O. Barnett, Jackson.

Council on Constitution and By-Laws

Term 1968-1971. Nominate two, elect one. Incumbent: Raymond S. Martin, Jr., Jackson.

Council on Legislation, Districts 1, 2, and 3

Terms 1968-1971. Nominate two for each district, elect one for each district. Incumbents: John G. Egger, Drew, District 1; James O. Gilmore, Oxford, District 2; and Frank M. Davis, Corinth, District 3.

Judicial Council, Districts 1, 2, and 3

Terms 1968-1971. Nominate two for each district, elect one for each district. Incumbents: E. LeRoy Wilkins, Clarksdale, District 1; R. L. Wyatt, Holly Springs, District 2; and T. N. Braddock, Jr., West Point, District 3. Dr. Wilkins is ineligible for re-election.

Council on Medical Service, Districts 4, 5, and 6

Terms 1968-1971. Nominate two for each district, elect one for each district. Incumbents: Paul B. Brumby, Lexington, District 4; John G. Caden, Jackson, District 5; and Guy T. Vise, Meridian, District 6. Dr. Vise is ineligible for re-election.

Council on Scientific Assembly

The following scientific sections (*not* the House of Delegates) will elect section secretaries for terms 1968-1971: Section on General Practice and Section on Eye, Ear, Nose, and Throat. All sections will elect chairmen.

State Board of Health

There are no members of the State Board of Health whose terms expire in 1968, and the House of Delegates will, therefore, make no nominations to the Governor at the 100th Annual Session.

Board of Trustees of Mental Institutions

Term March 17, 1969-March 17, 1975. Five nominees to be submitted to the Governor. Nominate and elect five. Incumbent: Victor E. Landry, Lucedale.

Board of Directors,
Mississippi Hospital and Medical Service

Terms 1969-1972, four posts. Nominate eight, select four receiving the greatest number of votes. Incumbents: S. Lamar Bailey, Kosciusko; Stanley A. Hill, Corinth; Joseph B. Rogers, Oxford; and James Grant Thompson, Jackson.

REPORT OF THE EXECUTIVE SECRETARY

Mr. Rowland B. Kennedy: Duties and Responsibilities. Your Executive Secretary is responsible for maintaining the headquarters office, for conducting the administrative affairs of the association, and for various fiduciary duties as required by Article VII of the Constitution and Section 7, Chapter VII, of the By-Laws. Because your Executive Secretary reports frequently and in detail to the Board of Trustees and general officers, this report is purposely brief and limited in scope.

Executive Staff: Since the 99th Annual Session, the regular workload of the executive staff has virtually doubled. Two factors account for this increase: The expansion of the CHAMPUS program and the additional work of the association, principally under the Board of Trustees. Four staff members have been added during the 1967-68 association year, all for the CHAMPUS department. The Board of Trustees and general officers are conversant with staffing needs and work volume which are closely and continually coordinated with them. It is especially gratifying that your association has been successful in recruiting and training staff members possessing excellent qualifications and specialized skills.

In addition to routine duties in membership, accounting, JOURNAL production, medical care plan administration, and staff assistance to the Board, officers, councils, and committees, your executive staff is regularly performing studies, surveys, socio-economic research, and supportive services relating to programs of the association.

Expression of the Staff. The staff is grateful for the opportunity of serving and in sharing some small part in the successes of the association. We deeply appreciate the *rapport* with all association officials and component medical societies, and we pledge our continued best effort in your behalf.

REPORT OF THE DELEGATES TO AMA

Reporting Format. Because of excellent reporting of AMA annual and clinical conventions through the *Journal AMA* and the *AMA News,* your Delegates to the American Medical Association have limited this report for the calendar year 1967 to a review of policy actions. The report is concerned with the Atlantic City annual and Houston clinical conventions. There were no special or called meeting of the House of Delegates in 1967.

Atlantic City Annual Convention. Your regularly elected Delegates, Drs. J. P. Culpepper, Jr., of Hattiesburg and Howard A. Nelson of Greenwood, were seated at the Atlantic City meeting, the 116th Annual Convention, June 18-22, 1967. Principal issues before the House of Delegates included therapeutic abortion, health care costs, government financing of health care, physician control over professional fees, postgraduate medical education, and the relationship of medicine and osteopathy. A record volume of business was considered by the House, a total of 151 items, including 123 resolutions from state medical associations, 18 reports of the Board of Trustees,

four reports of the Council on Medical Service, and six reports from other councils. There was 100 per cent attendance by the 242 members of the House.

For the first time since 1871, AMA policy on therapeutic abortion was substantially revised with a view toward introducing adequate safeguards to prevent abuse and to recognize scientific advances and ethical aspects. The policy permits the physician to exercise the dictates of personal conscience and medical judgment in the best interests of his patient. The policy expresses opposition to induced abortion except when (1) documented medical evidence indicates that continuation of the pregnancy may threaten the life or health of the mother, or (2) there is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or (3) there is documented medical evidence that continuance of the pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient; (4) two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing, and (5) the procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

The policy also states that it is ethical for physicians to provide medical information to state legislatures in consideration of legislation revising or developing laws on therapeutic abortion.

The House of Delegates recognized that the ability of the physician to serve his patient is being handicapped by rapidly rising costs of the various components of health care, and the House also stated that the problem of medical indigency will assume alarming proportions. The House frankly questioned the present organization and management of the nation's hospitals with respect to their "privilege of automatically translating all higher costs into higher prices."

The Delegates called for strengthening of voluntary insurance plans to provide better benefits, and a commitment was made to suggest guiding principles for health insurance and prepayment programs.

A large number of reports and resolutions dealt with the growing role of government in health care financing. The House reaffirmed the principle that no one should go without needed care because of inability to purchase it but also said again that responsibility first rests with the individual himself and then, to the extent that he is unable to pay, to the family, community, county, state, in that order, and only then to the federal government.

The House firmly and decisively gave support to Title XIX as the means for improving health care and the delivery of services to the needy of the nation. The policy called for organized medicine to take a leading role in "formulating and directing Title XIX programs at state level."

In codifying policies on physician control over the collection and disbursement of professional fees, the House stated that it is proper for a physician to establish the fee he charges with "the recognition that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge." The House agreed that it is proper for a third party to make payment of professional medical fees for patients. The principles of the Hess Report of 1949 and 1961 were reaffirmed in the disposition of professional services.

The Report of the Citizens Commission on Graduate Medical Education, popularly known as the Millis Report, was thoroughly discussed, but it has not as yet been formally placed before the House of Delegates.

Authorization was given to the Board of Trustees to begin negotiations to convert schools of osteopathy into schools of medicine, recognizing that funds of the AMA may be needed for this purpose. Medical manpower problems were reviewed, and a settlement of the problem over the disability insurance program was achieved. The program was continued with another carrier with guaranteed benefits and premium levels for five years. Several resolutions were adopted reaffirming the policy that a physician should be free to prescribe for his patient by brand or generic designation.

Your Mississippi Delegates introduced Resolution No. 72, subject: AMA Aims, based on actions taken at the 99th Annual Session in adopting Resolution No. 3, same subject, introduced by the Delta Medical Society. The resolution was referred to the Board of Trustees for action.

Houston Clinical Convention. The 21st Clinical Convention of AMA was conducted at Houston, Texas, November 26-29, 1967, and your association was represented by Dr. Howard A. Nelson of Greenwood and Dr. B. B. O'Mara of Biloxi, Dr. Culpepper being unable to attend. Two hundred thirty-eight of the 242 Delegates were seated and considered 96 items of business. Both Dr. Nelson and Dr. O'Mara served as members of reference committees of the House.

Health care and services, Medicare and Title XIX, health manpower, education, and Blue

(Turn to page 210)



The President Speaking

'Four Days in May'

TEMPLE AINSWORTH, M.D.

Jackson, Mississippi

THE 100TH ANNUAL SESSION is coming: It is probably the last meeting we will have in Jackson for some years to come; it may be the biggest in attendance; and it will certainly be one of the best in the 112 years of our association's history. This special issue of your JOURNAL furnishes you a fully detailed schedule from the first pre-session specialty society meeting through the final gavel in the House of Delegates. It's *your* meeting, organized by *your* state medical association, with the single idea of giving you four days of professionally profitable scientific sessions and personal enjoyment with your Mississippi colleagues.

We score a substantial first with our medical color television. The Smith, Kline and French Laboratories are sending in a full production unit to Jackson. Studios will be set up at the University Medical Center and a major portion of our program will be "live and in color" with surgery, wet clinics, patient demonstrations, and panels. Conventional scientific presentations from the meeting hall lectern will also be of high interest.

More than 70 scientific and technical exhibits will be presented, and more than a dozen specialty societies are sponsoring concurrent meetings. You will want to spend an evening with your medical alumni group, and then we'll bring back the nostalgic days of the "Roaring Twenties" at our annual association party.

Not the least important is our review of the year past and charting our course for the year to come in our House of Delegates. A number of reports are published in this issue in the Handbook so that every member may have the opportunity of seeing in advance something of the business before us.

This is our annual session, a team effort of many of our colleagues who have worked since last July in planning and organizing for these four outstanding days. Let's make them the best yet.

★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

Volume IX, Number 4

April 1968

EDITORIALS

American Hospitals: Versatile, Competent, and Short on Help

I

THE AMERICAN HOSPITAL is a phenomenally versatile and competent institution, and it is getting better every day. It is regrettably the center of raging economic controversy, because it is caught up in spiraling wages, the need to acquire new supplies and services at every-increasing costs, and it is the unfortunate payor of the cruelest tax of all, inflation. Yet, its capabilities increase with new developments and advancements in technology and with the growing efficiencies in the art and science of hospital management. The check book may protest, but the mortality tables show that as a vital component in the American system of medical care, the hospital is giving a good account for itself.

In the past 20 years, the number of hospitals in the United States has grown by 16 per cent, but the total number of beds is up 20 per cent. And the latter figure does not tell the full story on the improvements in modernization programs which are being carried out in virtually every hospital. In the same score of years, the number of voluntary hospitals rose by a third, while the number of tuberculosis institutions decreased by almost a half, another manifestation of advancement in medical science. But the real growth was among nonfederal government hospitals, up 99 per cent in numbers, a direct result of the Hill-Burton program. The number of federal hospitals rose only slightly during the two postwar decades, and there was actually a decrease in the total number of federal hospital beds, down by 13 per cent.

Psychiatric beds increased to about 640,000 in 1966 from 580,000 in 1947, but here again, there was a decline in the total number of institutions. So all told, the nation upped its hospital beds from 1.4 million to about 1.7 million, closed many long-term beds, modernized older institutions, and built double in nonfederal government hospitals. The real test, however, isn't in construction statistics but in service capabilities, and here is where the hospital as a unique institution shines.

II

Recent studies show that about 25 million Americans are admitted to hospitals each year for general medical and surgical, short-stay conditions. The biggest single segment of patients are on the obstetrical service, with these admissions totaling up an impressive 17.8 per cent of all patients. Digestive disorders come in second with just over a seventh of the patients going into this diagnostic category. Respiratory conditions, general injuries, and circulatory diseases are tagged third, fourth, and fifth, respectively. Skin disease is less frequent than any other condition among those admitted, being in last place at 1.1 per cent.

Among narrow scope admitting diagnoses, hernia is on one out of 20 charts, and GU disorders and conditions of the female breast make up a sizeable 9 per cent.

Without the physician, the hospital would be a

queerly useless institution, and the profession spends a substantial amount of its time rendering care to patients in this totally clinical environment. Taken by disciplines as a whole, physicians range from spending 100 per cent of their working time in hospitals (the pathologists) down to only 1.1 per cent (the allergists).

The surgical disciplines understandably devote more working time to hospital patients than the medical specialties. Thoracic surgeons lead with 70 per cent of their work in the hospital with the neurological, plastic, and colon and rectal surgeons coming in quite close. General surgeons represent the median time spent, about 44 per cent, with the otolaryngologists devoting only a quarter of their working hours in the hospital.

Among the medical disciplines, the general practitioner puts in 21.5 per cent of his professional hours in his hospital, about a third more time than the overall measure for the internist, pediatrician, and the psychiatrist.

III

Skilled personnel are the crucial quantities in the success or failure of the hospital. In 1966, there were about 150 such full-time employees for each 100 patients, an increase of 107 per cent in 20 years. This is an inclusive mean, because nonfederal psychiatric hospitals had only 47 employees per 100 patients, while voluntary, short-term hospitals had as many as 296 (in New England) down to 242 (in the West North Central region).

The help wanted sign is out at most hospitals, particularly among those allied professional individuals in short supply. Nurses, to the surprise of nobody, head the list with nearly 57,000 urgently needed and openings for as many as 83,000 for optimal care situations. LPN's and aides are second on the list with opportunities in the urgent classification totaling over 28,000. Psychiatric aides are critically short by 7,600, and hospitals say they could use over 31,000 of them.

The list continues on through medical technologists (4,100 needed), medical social workers (short by 2,000), dietitians (immediate openings for 1,600), and on with x-ray technicians, laboratory assistants, physical therapists, pharmacists, inhalation therapists, surgical technicians, and a host of specially skilled individuals.

The assignment of these allied professionals to patient care reflects something about the unusual cost index of the hospital. Mental patients require more skilled services than any other category of patients, followed by those admitted for digestive disorders, circulatory conditions, neoplasms, injuries, and diseases of the respiratory system.

Maternity patients require only 7.9 per cent of the hospital's total effort, while constituting the single largest group of patients. Exerting low care demands are those with congenital malformations, diseases of the blood, and skin and allergy conditions.

IV

The staffing, supply, construction, maintenance, and training aspects of the modern American hospital may lack the intensive interest and attention which the difficult cost factors now receive, but they are no less vital to building the astonishing capabilities and versatile service resources by which the hospital has come to be characterized.

Medicine at all levels of organization has a deep commitment to working with hospitals, and the success of the profession in rendering effective patient care is inexorably bound up with that of the hospital. Toward this worthy goal, the state medical association has earnestly recommended that physicians serve as members of hospital governing boards as the most effective way of building real liaison with hospital trustees and administrators. The American Medical Association takes the same position.

In an age where some disease entities have become the conquered killers and the forward thrust of medical science continually accelerates, it is something of an irony for the wealthiest nation in the world to have the economics of hospital care as its chief concern about these vital institutions. There are troubled signs on the horizon as costs continue to rise, but scientific ingenuity can and must find ways to fulfill critical personnel needs in hospitals while seeking reasonable solutions to the problem with the dollar mark.—R.B.K.

Fluoridation: First by Law, Now by Decree

With the addition of Illinois and Michigan, there are now five states with mandatory requirements for fluoridation of public water supplies. A number of major U. S. cities add fluoride to water as a municipal function. One of three Americans drinks water to which the decay-preventive has been added over and above those who have the benefit of naturally occurring fluoride in local water supplies.

The American Dental Association has stayed in the forefront of the battle for fluoridated water. A

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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Syracuse, New York 13201

valuable ally was picked up in 1961 with endorsement of the program by the American Medical Association. Most state medical associations also endorse fluoridation in amounts of one part per million. This is the policy of the Mississippi State Medical Association.

Illinois has enacted a fluoridation law which gives communities until July 1, 1968, to adjust the fluoride content in public water supplies. The program is ahead of schedule with three-fourths of all Illinois citizens now drinking fluoridated water. A total of 192 Illinois communities are already adding the chemical, and 144 communities have sufficient natural fluorides to meet the minimum.

In Michigan, fluoridation was achieved by regulation of the state board of health which requires public water supplies serving 1,000 persons or more to adjust the content and maintain between 0.9 to 1.2 ppm. The Michigan health officer, Dr. Albert E. Heustis, has stated that "it being the ultimate duty of this department to see that the public is provided a wholesome water in accordance with current scientific knowledge in the field of public health, it is my considered judgment as a physician and as director of the Department of Public Health that fluoride in properly controlled amounts is a necessary component of wholesome water."

The Michigan regulation requires fluoride in the definition of a "wholesome water supply."

Pioneer states in providing fluoridation by law were Connecticut and Minnesota. Kentucky has a public health water supply regulation similar to that of Michigan.

The chief obstacle to fluoridation is raised by chiropractors and other cultists who maintain that it is a deadly poison. Their principal weapon is to secure a referendum and then raise all sorts of outlandish charges to generate fear on the part of the electorate. Many observers believe that the best approach to universal fluoridation is through public health regulation or an enactment of the legislature.

The scientific case for fluoridation is overwhelmingly proved as a positive benefit to dental health. The list of states giving attention to this important step will continue to grow.—R.B.K.

Medicine Accredits Another Allied Field

The provision and delivery of health services in the United States are mammoth endeavors. Were we to size up the health care industry—admittedly a poor description for professional activities—we would be talking about a total effort second only to construction in the total of individuals involved in any single nonagricultural field.

More Americans are engaged in full time health care services than build automobiles, maintain communications, run air lines or railroads or ships on the seas, than engage in merchandising services or carry on the business of any single other field, except construction. In Jackson, it is reliably estimated that only those in state government exceed the total health care team as the city's single largest occupational group.

It is no wonder that the allied health professions are mushrooming and that their relation to physicians and hospitals are posing new challenges and often, new problems as well. New looks at these aspects of health services have been initiated by the American Medical Association, but its major efforts in these respects are still directed at support for these allied colleagues.

The AMA Council on Medical Education has recently inaugurated its ninth program for approval of an allied health profession. Working with the American Society of Clinical Pathologists, AMA has established an approval program for certified laboratory assistants. Prior to this milestone action, only ASCP worked with this group, and it was a young program, having been established in 1963. The prescribed training now requires 12 months in an approved laboratory or hospital school and an examination upon graduation as prerequisites for the designation, C.L.A.

AMA maintains accreditation standards for medical records librarians, medical records technicians, physical therapists, medical technologists, x-ray technologists, occupational therapists, cytotechnologists, and inhalation therapy technicians. This would be a considerable education accreditation and approval program if taken by itself, but AMA also carries on the even more substantial program among medical schools and postgraduate programs for physicians, including all approved internships and residencies.

So when a less-than-thoughtful nonmedical friend wonders about what AMA does, it is a source of satisfaction to remind him that it is insuring the quality of health services by meticulously monitoring the training of the second biggest endeavor in the United States, all financed voluntarily by physicians through their professional organizational dues.—R.B.K.

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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New Standards for Nursing Homes

The enactment of Medicare in 1965, in addition to the many obvious things it brought to pass, turned the spotlight on nursing homes. By furnishing a financing base for program beneficiaries, the government characteristically assumed prerogatives with reference to standards, although these are largely left to the state when determinations are made. The 1967 amendments boost this initial movement forward, especially where Title XIX is concerned. In every instance, the state will make the determination.

The law now provides for medical evaluation, management, and review of nursing home patients under a state's Title XIX plan. The state, through its agency which licenses and regulates nursing homes, must conduct periodic inspections of the care provided, adequacy of services for patients, the necessity and desirability of continuing to place patients in the facilities, and make reports of inspections.

Disclosure as to ownership, patient records, utilization review, medical supervision of patients, dietary policies and services, liaison with hospitals for certain diagnostic and other services, and maintenance of nursing home facilities in accordance with the Life Safety Code of the National Fire Protective Association are mandatory upon these care facilities.

By July 1, 1970, states must provide for licensure of nursing home administrators by the agency which is responsible for licensing under the healing arts act. In Mississippi, this is the State Board of Health which is already responsible for the licensure and regulation of nursing homes and medical licensure.

In this new innovation and health care standard, the state will devise and impose standards which must be met by licentiates, administer examinations, and monitor performance. The state is further charged with monitoring the administration of nursing homes with a view toward increasing quality of care and improving facilities administration. The law limits the authority of a state to issue waivers or provide grandfather clauses.

Also created in the 1967 amendments is a National Advisory Council on Nursing Home Administration charged with the responsibility of advising the federal and state governments on the conduct of the program. The council will study and identify the core of knowledge which should constitute minimal qualification in nursing home administration. Looking forward to state conduct

of these programs, the council will have a statutory life from its creation by or before June 1, 1968, and it will cease to exist on December 31, 1971.

Prompt action by states—under their respective laws and locally devised regulations—will give physicians useful yardsticks with which to measure the capabilities of a nursing home in terms of patient care, and the state will have assurances that it knows what it is purchasing in behalf of the needy.—R.B.K.

POSTGRADUATE CALENDAR

DIABETES SEMINAR

University Medical Center
April 11, 1968, beginning at 9 a.m.

Sponsored by the University of Mississippi School of Medicine postgraduate education committee and the Department of Medicine with support from The Diabetes Association of Mississippi and the U. S. Vitamin Pharmaceutical Corporation.

Participants:

Max Miller, M.D., professor of medicine, Case Western Reserve University School of Medicine, and director, Clinical Research Center, University Hospitals, Cleveland, Ohio

Joseph C. Shipp, M.D., associate professor of medicine, University of Florida College of Medicine, Gainesville, Fla.

Samuel B. Johnson, M.D., clinical associate professor of surgery, and chief, Division of Ophthalmology, University Medical Center

Herbert G. Langford, M.D., professor of medicine, associate professor of physiology and biophysics, University Medical Center

Karleen C. Neill, M.D., instructor in medicine, and director, Diabetes Clinic, University Medical Center

Robert R. Smith, M.D., instructor in neurosurgery, University Medical Center

Thursday Morning

CONTROVERSIAL PROBLEMS IN DIABETES MELLITUS
Dr. Miller

removes the mental blur

that clouds vision

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Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
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Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

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Solfoton *(yellow, uncoated tablets "P")*
100s, 500s, 5000s

Solfoton Capsules *(yellow and brown)*
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Solfoton S/C *(sugar-coated beige tablets)*
100s, 500s, 4000s

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POSTGRADUATE / Continued

Hypoglycemia
Dr. Langford

The Diabetic Eye
Dr. Johnson

Surgery Grand Rounds: Hypophysectomy for Diabetic Retinopathy
Dr. Smith

Thursday Afternoon

Oral Hypoglycemic Drugs
Dr. Neill

Recognition and Management of Insulin Resistance
Dr. Shipp

Discussion

CIRCUIT COURSES

Southwestern and East Central Circuits

Natchez—April 16, Jefferson Davis Memorial Hospital, 7 p.m.

Meridian—May 7, Northwood Country Club, 6:30 p.m.

Session 3—A Practical Approach to Diagnosis and Management of Diarrhea, Dr. Lidio Mora

Current Practices in the Diagnosis and Management of Pancreatitis, Dr. Albert Meena

Eastern Circuit

Columbus—April 23, Aubrey and Ellon's Restaurant, 6:30 p.m.

Session 3—Thyroid Problems in Infants and Children, Dr. Jose Montalvo

Eye Ground Manifestation of Systematic Disease, Dr. Samuel Johnson

FUTURE CALENDAR

April 1-2
American Board of Surgery

April 2
Circuit Course, Meridian

April 11
Diabetes Seminar

April 16
Circuit Course, Meridian

April 18, 19
Cardiac Nursing Seminar

April 18
Thoracic Society

April 23
Circuit Course, Columbus

May 7
Circuit Course, Meridian

May 13-16
Mississippi State Medical Association



NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

Arrington, George Lamar, Jr., Ocean Springs. Born Meridian, Miss., July 20, 1937; M.D., Tulane University School of Medicine, New Orleans, La., 1962; interned Charity Hospital, New Orleans, one year; ENT residency, Charity Hospital, New Orleans, three years; surgery residency, Ochsner Hospital, New Orleans, one year; Captain, U. S. Air Force; elected Dec. 7, 1967, by East Mississippi Medical Society.

Bird, Billy Joe, Biloxi. Born Bartlesville, Okla., Oct. 23, 1930; M.D., University of Oklahoma School of Medicine, Oklahoma City, 1957; interned V.A. Hospital, Oklahoma City, one year; psychiatry residency, Topeka State Hospital and Menninger School of Psychiatry, Topeka, Kansas, five months; psychiatry residency, Tulane University School of Medicine, New Orleans, La., two years; psychiatry residency, Langley Porter Neuropsychiatric Institute, San Francisco, Calif., two years; elected Nov. 8, 1967, by Coast Counties Medical Society.

Clement, William Rodney, Handsboro. Born Pontotoc, Miss., July 28, 1932; M.D., Tulane University School of Medicine, New Orleans, La., 1957; interned Charity Hospital, New Orleans, one year; dermatology residency, Charity Hospital, New Orleans, La., three years; elected Jan. 3, 1968, by Coast Counties Medical Society.

Davis, John Jennings, Jr., Meridian. Born Abita Springs, La., May 20, 1925; M.D., Louisiana State University School of Medicine, New Orleans, 1948; interned Mercy Hospital, New Orleans, La., one year; residency, Mercy Hospital, New Or-

leans, La., six years; member, American Society of Clinical Pathologists and College of American Pathologists; diplomate, American Board of Pathology; elected Dec. 7, 1967, by East Mississippi Medical Society.

DILL, ANDREW ROBERT, Columbus. Born Clay County, Miss., July 26, 1937; M.D., University of Mississippi School of Medicine. Jackson, 1963; interned Mobile General Hospital, Mobile, Ala., one year; internal medicine residency, Kennedy V.A. Hospital and University of Tennessee College of Medicine, three years; elected Dec. 12, 1967, by Prairie Medical Society.

DUNN, FELIX HENRY, Gulfport. Born Biloxi, Miss., June 29, 1930; M.D., Meharry Medical College, Nashville, Tenn., 1952; interned Homer G. Phillips Hospital, St. Louis, Mo., one year; elected Nov. 8, 1967, by Coast Counties Medical Society.

MOORE, EDWARD LOWRY, Meridian. Born Meridian, Miss., March 17, 1936; M.D., University of Mississippi School of Medicine, Jackson, 1961; interned Memorial Hospital, Savannah, Ga., one year; ophthalmology residency, University of Cincinnati, Cincinnati, Ohio, three years; elected Dec. 7, 1967, by East Mississippi Medical Society.

STEWART, WORLEY K., Pass Christian. Born Warrensburg, Mo., Aug 28, 1930. M.D., Missouri University, Columbia, Mo., 1961; interned Brooke General Hospital, Fort Sam Houston, Tex., one year; general practice residency, Lafayette Charity Hospital, Lafayette, La., one year; elected June 12, 1967, by Coast Counties Medical Society.

DEATHS

GRAY, ARCHIE LEE, Jackson. M.D., University of Tennessee College of Medicine, 1930; interned, Memphis General Hospital; M.P.H., Harvard University, 1932; postgraduate training in obstetrics and pediatrics, the Tulane University School of Medicine, 1945. Director, Preventable Disease Control, Mississippi State Board of Health, 1933-1958; Executive Officer, 1958-1968. Clinical assistant professor of preventive medicine, University of Mississippi School of Medicine. Diplomate, American Board of Preventive Medicine. Chairman, Committee on Infectious Diseases. Association of State and Territorial Health Officers; member, State Medical Education Board, Mississippi Commission on Hospital Care, Mississippi Interagency Council on Mental Illness and Retardation, Surplus Property Procurement Commission, State Embalming Board, Pearl River Valley Water Supply District Board, and advisory committees to the Surgeon General of the United States on Venereal Disease Control, Oral Poliomyelitis Vaccine, Tuberculosis Control, and Measles Vaccine. Member, Central Medical Society, Mississippi State Medical Association (member of the House of Delegates), and American Medical Association. Died March 4, 1968, aged 68.

Wyeth Supplies First Coral Snake Antivenin

The first U. S. licensed and produced antivenin to combat the potent poison from the North American eastern coral snake has been developed by Wyeth Laboratories and is now available in the nine states where coral snakes are found. Wyeth Laboratories, Philadelphia pharmaceutical manufacturer, has donated as a public service enough antivenin (Micrurus fulvius) to treat patients bitten by the eastern coral snake.

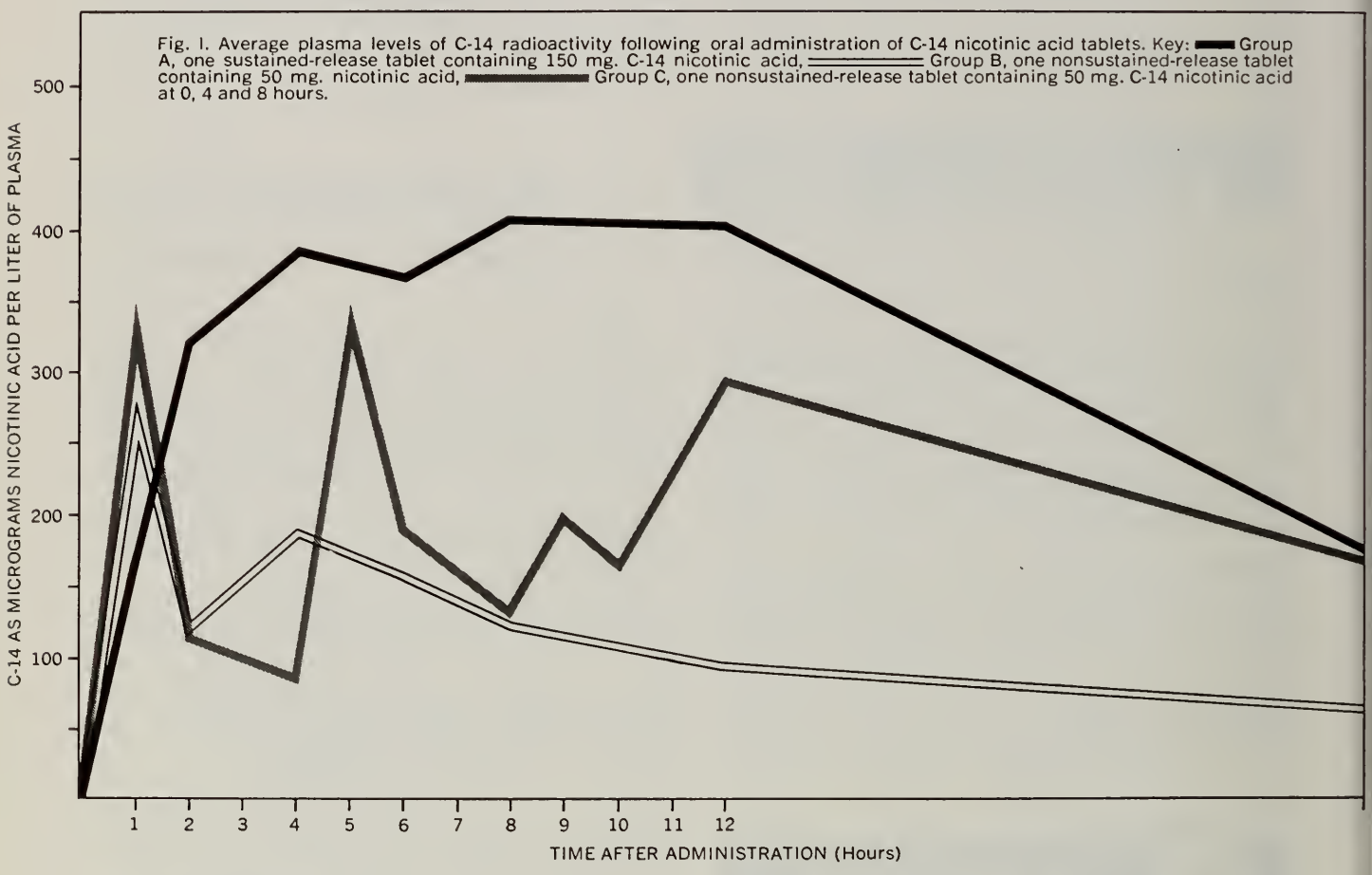
In the ceremonies at the National Communicable Disease Center headquarters in Atlanta, Lex M. Cowsert of Wyeth's Washington, D. C., office, presented a supply of antivenin (Micrurus fulvius) to Dr. David J. Sencer, Director of the National Communicable Disease Center of the United States Public Health Service. Additional supplies will also be presented to state health departments and poison control centers in the states of Georgia, Florida, Alabama, Arkansas, Louisiana, Mississippi, North Carolina, South Carolina and Texas.

These states cover the total area in which Micrurus fulvius—the eastern coral snake and a subspecies M. f. tenere—are found. Wyeth Laboratories is supplying the coral snake antivenin without charge to designated centers in these states so that antivenin will be available immediately whenever a coral snake bite is reported.

Physicians and public health officials within the area where coral snakes are found have been concerned for a number of years because no U. S. licensed coral snake antivenin was produced in this country. Through the collaboration of the Division of Biologic Standards of the National Institutes of Health and Wyeth Laboratories, studies were conducted on the coral snake venom to develop the antitoxin.

Sustained circulatory, respirator and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

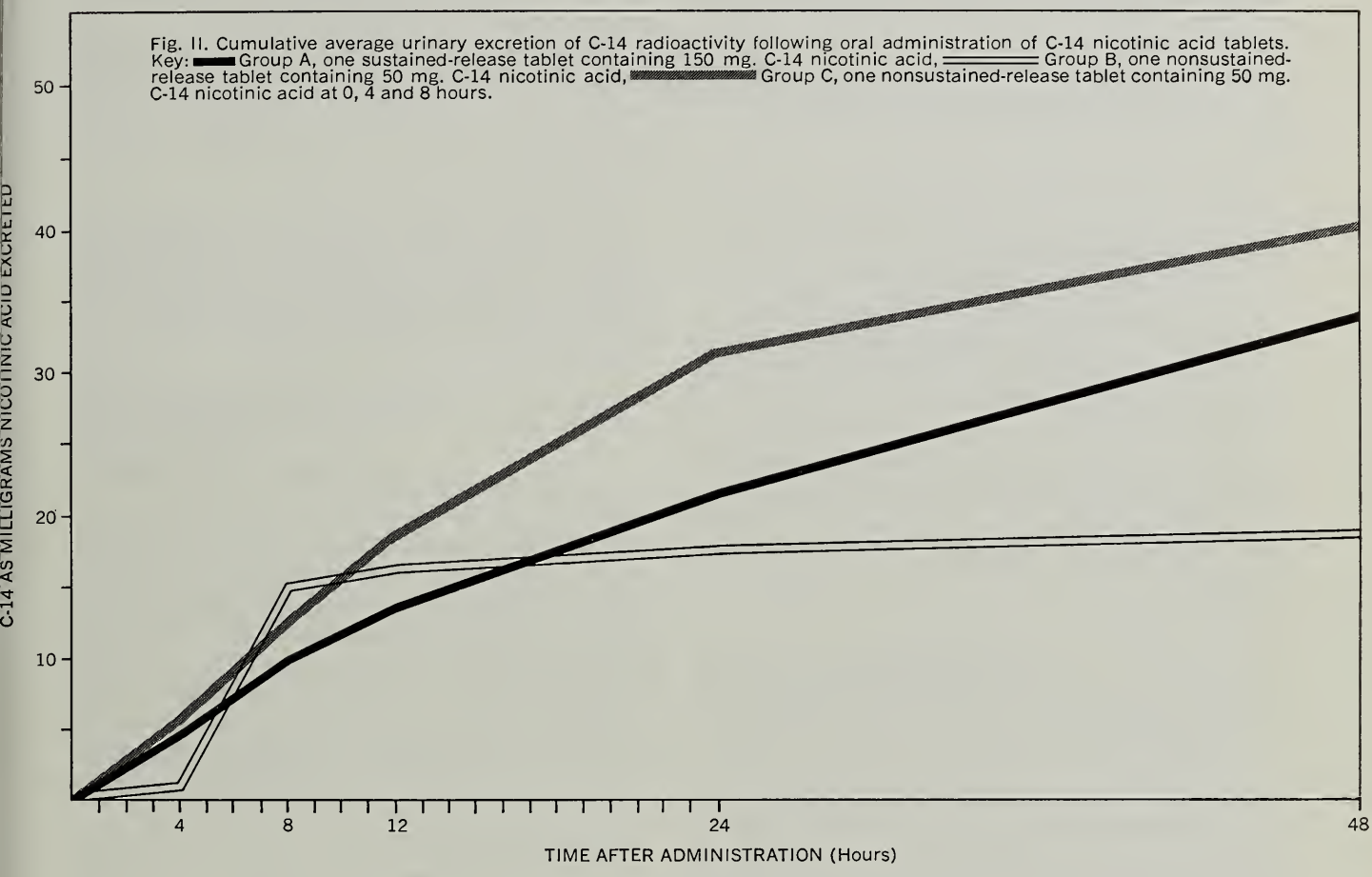
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

Medicine-Insurance Congress Will Meet

A congress on medicine and insurance, co-sponsored by the Association of Life Insurance Medical Directors of America and the American Medical Association, has been scheduled June 15 in San Francisco.

The meeting, which will immediately precede the AMA annual meeting (June 16-20), is the first of its kind between the two medical organizations.

The program planned will be designed to create a deeper understanding of the relationships between life insurance medical directors, medical examiners and attending physicians.

It is expected that the day's activity will include two symposiums, and a luncheon program.

Dr. Milford O. Rouse, president of AMA, will deliver the keynote address.

Others scheduled to take part include: Dr. James P. Cooney, senior vice president for medical affairs of the American Cancer Society, and Earl Clark, president and chief executive officer of Occidental Life Insurance Company of California.

UA Opens New Animal Research Project

A Department of Comparative Medicine has been established at the Medical Center, University of Alabama in Birmingham, according to an announcement by the deans of the Medical College and School of Dentistry, Dr. S. R. Hill, Jr. and Dr. Charles A. McCallum, Jr. The appointment of Dr. Russell Lindsey as professor and chairman of the department was simultaneously announced.

"Creation of the new department reflects the Medical Center's commitment to excellence in the care and health of its research animals, and thus to research of the highest quality," the deans said. "It is also anticipated that members of this department will establish one of the Center's very distinguished research and training programs."

Dr. Lindsey and his staff will not only direct the care of all animals in the Center but perform a variety of teaching and research functions concerning laboratory animals.

Dr. Lindsey, whose background encompasses veterinary training as well as broad postdoctoral training in a medical center environment, is a graduate of the University of Georgia and Auburn University. He served a fellowship in pathology at the Johns Hopkins University School of Medicine.

The faculty will eventually include five full-time members. At the present time two faculty members have been recruited in addition to Dr. Lindsey. These include Dr. Henry J. Baker and Dr. T. W. Weatherford, III. Dr. Baker is associate professor and Dr. Weatherford, instructor.

"For every disease in man there is probably an almost identical one which occurs naturally in animals," Dr. Lindsey said. "It is possible to study these animal models of human disease under a wide variety of conditions to the ultimate benefit of both man and lower animals."

Dr. Lindsey said members of the department would be working closely with Birmingham's Jimmy Morgan Zoo, studying the animals' natural diseases which may occur from time to time.

Cancer Seminars Are Set by UMC

During the current academic year, the University of Mississippi Medical Center is offering weekly programs on various aspects of cancer diagnosis and management under the auspices of the Tumor Clinic Committee and with the aid of a U.S.P.H.S. Clinical Cancer Training Grant. The series, held on successive Tuesdays, is open without fee to all physicians. Meetings are held in Room 3-A at the University Medical Center from 5 to 6 p.m.

The current schedule is:

April 2—Carcinoma of the Prostate: Dr. James Keeton, surgery resident

April 9—Management of Disseminated Breast Cancer: Dr. C. Stratton Hill, Jr., Department of Internal Medicine, M. D. Anderson Hospital and Tumor Institute, Houston, Texas

April 16—Gastric Carcinoma: Dr. Edward Lowicki, assistant professor of surgery

April 23—Estrogens, Endometrial Hyperplasia and Endometrial Carcinoma: Dr. Ronald R. Greene, professor of obstetrics and gynecology, Northwestern University Medical School, Chicago, Illinois

April 30—Skin Cancer: Dr. James G. Thompson, clinical assistant professor of medicine and chief of the division of dermatology

State's Insurance Prepayment Coverage Is Analyzed by Health Insurance Institute

The Health Insurance Institute, the research and study arm of the private insurance industry, told the state medical association in a recent report that "a high level of health insurance protection has been reached in the state of Mississippi." The Institute said that 1,279,000 Mississippians under age 65 were protected by some form of hospital expense insurance.

The special study took into account protection offered and benefits provided by 307 insurance companies licensed to do business in the state, the combination Blue Cross-Blue Shield plan, two independent plans, and the Mississippi State Medical Association-administered program for dependdents of active duty military personnel, retired service members and their immediate families, and certain survivors of deceased military personnel, the Civilian Health and Medical Program of the Uniformed Services.

The HII study covered less than 2 million Mississippians, because more than 200,000 over-65 seniors were automatically subtracted because of Medicare coverage. Most insurance and voluntary prepayment programs "carve out" Medicare benefits from senior contracts, paying only part or all of costs not covered under Title XVIII's Parts 1-A and 1-B. Of the under-65 state population, over 1,279,000 have hospital expense coverage, about 1,087,000 have surgical expense coverage, and only 751,000 carry regular medical coverage. The number of persons with major medical benefits among 310 insurance carriers, the Blue plan, and independent plans totals a skimpy 280,000, slightly over 10 per cent of the total population.

Excluded from classification by extent of benefits is the association-administered CHAMPUS program which covers usual, customary, and prevailing charges for inpatient medical and surgical services. Benefits levels for outpatient services are similar but subject to a $50 annual deductible and a co-pay provision. No other Mississippi health care program approaches these benefit levels.

Additionally, the CHAMPUS program covers the costs of outpatient prescription drugs, prescribed either by brand name or generic designation, also subject to deductible and co-pay provisions applied to outpatient care.

The Institute reported that more than $57.7 million was paid in health care benefits to Mississippians last year for those under age 65. The studies said that admissions to 95 general medical and surgical hospitals in the state totaled over 288,700 and made use of 7,534 hospital beds. Care was rendered privately by 1,385 physicians who had an average daily inpatient load of 5,151 on hospital census lists. The mean stay was 6.5 days per patient who paid an average hospital bill of $238, substantially under the national mean.

The Institute also reported that dental services in the state were rendered by 657 privately practicing dentists and that there were 1,037 active practicing pharmacists. The nurses register listed 3,213 nurses.

Mississippi hospitals employed 242 full time workers in all levels of professional and nonprofessional jobs per 100 patients, HII said.

The study was a detailed analysis of the annual overall health care and costs survey conducted by the Health Insurance Institute. Data for Mississippi are qualified by the elimination of duplication in health and medical insurance coverage by counting only one policy per individual considered in the survey. Only those under age 65 with health insurance or voluntary prepayment contracts are included, the Institute said.

The data are generally quantitative, association spokesmen noted, because the adequacy of coverage is not evaluated in the survey report. Criterion for including an individual is ownership or benefi-

cial enjoyment of coverage under a health insurance or voluntary prepayment contract.

It was also noted that ratios for health service expense protection among Mississippians are apparently lower than those for all Americans. Elsewhere in this issue of the JOURNAL, a major editorial analyzes current health service costs and also considers extent of insurance and Blue plan coverage in the United States.

About 210,000 Mississippians over age 65 are covered under Medicare's Part 1-A for hospital services, and more than eight out of 10 have the supplementary medical insurance coverage under Part 1-B. Claims now being processed in the state for SMI-covered services, principally those of physicians, appear to be stabilizing at about 180,000 per year in an $8 million program.

Also in the health services picture are veterans who receive care in the state's three VA hospitals. Mental patients receive care in the Mississippi State Hospital at Whitfield, the East Mississippi Hospital at Meridian, and the Ellisville State School. Just under 500 beds in the four state charity hospitals account for nearly 100,000 admissions annually, while the pared-down State Hospital Commission program with a $12.50 per diem allowance to participating hospitals covers some indigent patients under age 65, following program restrictions introduced with the inception of Medicare.

The CHAMPUS program, also serving those under age 65, appears to be growing toward a level of 25,000 with gross benefits of $1.2 million. It is the only program in the state which, in addition to providing usual, customary, and prevailing fees for all beneficiaries, furnishes outpatient prescription drugs.

AMA Renames Dr. Lotterhos to Council Post

Dr. William E. Lotterhos of Jackson has been reappointed a member of the Council on Scientific Assembly of the American Medical Association. The appointment was made by the AMA Board of Trustees and announced to the state medical association by Dr. Wesley W. Hall of Reno, Nev., chairman.

Dr. Lotterhos is currently serving as chairman of the board of directors of the American Academy of General Practice and as speaker of the House of Delegates of the state medical association. He also holds membership on committees of AAGP, AMA, and MSMA.

Dr. Davis Is Named New Mid-South President-Elect

Dr. J. T. Davis of Corinth has been named president-elect of the Mid-South Postgraduate Medical Assembly during the recent 79th Annual Session at Memphis. Dr. W. K. Tilley of Lebanon, Tenn., was inaugurated president, succeeding Dr. Charles G. Swingle of Marked Tree, Ark.



Dr. Davis

Elected vice presidents of the assembly were Drs. William R. Peebles of Union, Miss., Robert McCreary of Hot Springs, Ark., Eugene Nobles of Memphis, and Walker Dempsey of Red Bay, Ala. Dr. Henry G. Rudner, Jr., of Memphis continues to serve as secretary-treasurer.

During 1967-1968, Dr. William B. Howard of Pontotoc served as vice president from Mississippi.

Dr. Davis, an active leader in the Mississippi State Medical Association, is a member of the Board of Trustees and chairman of the Council on Budget and Finance. He received his M.D. from Vanderbilt University School of Medicine and practices general surgery at Corinth. He is a Fellow of the American College of Surgeons.

The three-day annual session was headquartered at the Holiday Inn-Rivermont. Fifteen guest essayists appeared on the multi-discipline program with papers representing anesthesiology, general practice, general surgery, internal medicine, neurology, ob-gyn, orthopaedic surgery, pediatrics, psychiatry, radiology, thoracic surgery, and urology.

The session also presented 54 technical exhibits and 20 scientific booths. Three specialty societies representing ob-gyn, neurology, and radiology conducted concurrent meetings as did medical alumni groups. The University of Tennessee sponsored 18 class reunions of medical graduates. A golf tournament, luncheon and banquet occasions, and special entertainment for the ladies topped off the balanced program.

Mr. Leslie H. Adams of Memphis is executive director of the group, and he coordinated meeting planning and arrangements.

Tissue Typing Is Funded by MHA

A new $3,000 grant from the Mississippi Heart Association to Dr. Patricia Moynihan, second year surgery resident, will set up a laboratory for tissue typing at the University of Mississippi Medical Center.

Dr. Moynihan will use a method called serotyping to try to predict tissue compatibility for proposed organ transplants. Serotyping, developed by the distinguished immunologist, Dr. Paul Terasaki at the University of California at Los Angeles, tests white cells removed from blood samples of donor and recipient against a panel of known antisera ordered from the National Institutes of Health.

The University of Mississippi Medical Center tissue typing laboratory is the fourth of its kind in the nation. Others are at the University of California at Los Angeles, the Medical College of Virginia and the University of Colorado.

Philips Roxane Get Vaccine Contract

For the third successive year, a federal contract for measles vaccine has been awarded to Philips Roxane Laboratories, Inc., a wholly-owned subsidiary of Philips Electronics and Pharmaceutical Industries Corp. (ASE), it was announced by Oliver H. Brewster, president of the parent company.

The contract was awarded by the Veterans Administration in association with the Communicable Disease Center, an agency of the U. S. Public Health Service. In the two years the CDC program has been underway, there has been a dramatic reduction in the number of cases reported.

Under the terms of the contract, Philips Roxane will provide its Measles Vaccine to CDC for all single-dose and ten-dose vials. The contract runs from February 16, 1968, to January 31, 1969, but may be extended at the government's option for as long as one year.

The new contract calls for the delivery of a minimum of 700,000 doses of vaccine but stipulates that Philips Roxane Laboratories must be prepared to deliver 1,200,000 doses. Based on past experience, it is expected that the volume actually delivered under the contract will be substantially higher.

The vaccine, which contains the Edmonston B strain, was developed by the PEPI subsidiary

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Vitamin B_{12}	50 mcgm
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Niacinamide	30 mg
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Measles is acknowledged by medical authorities to be a serious infection with substantial mortality rates among children. It leaves one child in five with such severe aftereffects as loss of hearing and even brain damage.

In its program to eradicate measles, the Communicable Disease Center makes vaccine available to state and local health departments for the immunization of preschool children. In addition, any physician can receive the vaccine from his local health department at no charge.

Category Coordinators Are Named by RMP

Two additional categorical coordinators have been named for the Mississippi Regional Medical Program. Dr. Robert R. Smith, instructor of neurosurgery at the University Medical Center, will coordinate stroke planning. Dr. Thomas M. Blake, associate professor of medicine at the University Medical Center, is current coordinator for the heart committee.

They join other University Medical Center faculty who are Regional Medical Program staff members: Dr. Guy Campbell, coordinator of Regional Medical Programs in Mississippi; Charles Hudson, assistant to the coordinator, and Dr. Guy Gillespie, cancer coordinator.

NIH Previews Isotope Diagnosis

Scientists of the Public Health Service's National Institutes of Health have developed a new technique that employs the radioisotope technetium-99m and a gamma scintillation camera to visualize the heart and great vessels.

The resulting "radioisotope angiocardiogram" provides diagnostic information on the anatomy and function of the heart and great vessels similar to that obtained by conventional x-ray visualization techniques, but it eliminates the adverse reactions that occasionally attend injection of radiopaque dyes required for adequate x-ray definition. When injected in large quantities, these dyes can produce nausea, slowing of the heart, and even shock.

The new method was reported in San Francisco at the 17th Annual Scientific Session of the American College of Cardiology by Drs. Dean T.

Mason, Lawrence S. Cohen, and Eugene Braunwald, of the Cardiology Branch, National Heart Institute; and Drs. William L. Ashburn and John C. Harbert, of the Department of Nuclear Medicine, NIH Clinical Center.

It entails injecting a small quantity of technetium-99m via catheter into a selected heart chamber or blood vessel. The radioisotope emits gamma rays. These are detected by a gamma scintillation camera positioned over the patient's chest. The camera contains a crystal that scintillates—e.g., emits flashes of light—whenever gamma rays strike it. A television camera then records the flashes from the scintillation camera.

As the isotope transverses the heart and great vessels, its gamma emmissions define anatomic details and bloodflow patterns that are highly useful in the diagnosis of congenital or acquired heart disorders. The radioisotope and angiocardiogram can also be recorded on videotape and replayed for detailed analysis.

Radiation exposure to the patient is minimal. The technique requires only small quantities of technetium-99m. Moreover, the isotope is rapidly cleared as it passes through the lungs and subsequently leaves the body in the urine.

The scientists have tested the technique in patients at the time of diagnostic catheterization for a variety of congenital and acquired forms of heart disease. They report that the radioisotope angiograms accurately reflected hemodynamic alterations resulting from these conditions.

Infertility Booklet Is Offered by AMA

AMA has prepared a new brochure for use by practicing physicians in furnishing answers to patients who apparently cannot have children. Entitled "Infertility," the pamphlet describes in nontechnical terms the factors essential to fertility, suggests where the trouble may lie, and offers suggestions for solutions.

The pamphlet makes a point that if failure to achieve a planned pregnancy persists for more than a year, the couple should seek professional care in finding out why, rather than senselessly accuse each other or develop feeling of inferiority over the inability to procreate.

AMA members may obtain single review copies from the Department of Health Education at the Chicago headquarters. Quantity purchases range from 10 cents per copy for 100 down to 4 cents each when 1,000 or more are ordered.

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Shield were major items for action by the House.

The House took a vigorous stand supporting care standards that are purely local in development and nature, opposing the disturbing trends toward possible establishment of medical care standards on a national basis. Another action committed the AMA, the profession, and state associations to informing the public as to practical means of moderating rising health care costs, the value of voluntary health insurance, and the expansion of medical manpower. Encouragement for involvement of the profession in comprehensive health planning and a critical examination of professional liability implications in utilization of allied professional personnel were sought.

The House again supported direct billing under Part 1-B of Title XVIII, and asked that AMA continue efforts for implementation of Title XIX in such a way as to recognize "the physician's right to bill directly all patients, including Title XIX patients," and which "allows the physician or his patient to be reimbursed his usual, customary, and reasonable fee for his professional services."

Resolutions were adopted urging membership of physicians on hospital governing boards as the best means for effective liaison between medical staffs and governing authorities, for protecting hospital privileges through "due process," calling for better liaison between hospital staffs and local medical societies, for simplifying attendance requirements for staff meetings, and for pressing for prompt revision of JCAH rules on use of externs in non-university-affiliated hospitals.

In a special report, the Board of Trustees presented a new 11-point positive statement on the aims of AMA, an outgrowth of Resolution No. 72, introduced by your Delegates. This new statement of purposes and responsibilities greatly enlarges AMA aims and takes into account the goals and objectives contained in the Mississippi position.

The House approved in principle relocation of the AMA-ERF Institute for Biomedical Research from the Chicago headquarters building to the University of Chicago campus. Under a new procedure, the House voted to present the 1968 AMA Distinguished Service Award to Dr. Owen H. Wangensteen at the San Francisco annual convention. A number of revisions of the By-Laws were adopted, and these related to organization of the AMA.

In three actions on Blue Shield, the House voted to request the Council on Medical Service to develop guiding principles for improvement of programs, second, to make a determination of the proper objective of voluntary health coverage, and third, calling "upon medical society officers and executives to participate in the activities of their respectively sponsored or approved plans so that all such plans shall, in fact, be and continue to serve as economic arms of the medical profession in offering sound alternatives to the public in the voluntary financing of health care."

Retirement of Delegate. Your incumbent senior AMA Delegate, Dr. Nelson, reports that after serving eight consecutive terms, 16 years, during which he also served as an AMA committee chairman, Vice President, and a member of the Board of Trustees, Dr. J. P. Culpepper, Jr., of Hattiesburg retired as Delegate to AMA from Mississippi. On January 1, 1968, Dr. G. Swink Hicks of Natchez began service as a Delegate, and he will be seated at the San Francisco annual convention.

Expression of Delegates. Your AMA Delegates express appreciation to the state medical association's Board of Trustees and general officers for guidance and support and for the continuing communication among us which enables us to represent the policies and wishes of our association in the AMA House of Delegates.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

99th Annual Session. At the 1967 annual session, there were no pending amendments to the Constitution or By-Laws, and none was acted upon during the meeting. One amendment to the By-Laws was introduced on the final day of the 99th Annual Session to lie on the table for one year for consideration at the 100th Annual Session.

Resolution No. 7. At the adjourned meeting of the House of Delegates on May 18, 1967, Drs. S. Lamar Bailey and H. C. Ricks introduced Resolution No. 7, subject: Limitation Upon Terms of AMA Delegates. The resolving clause is as follows:

> *Resolved,* That so much of Section 6, Chapter V, By-Laws of the Mississippi State Medical Association as reads: "It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two successive years," be amended to add the following: "provided, however, that no individual so elected shall serve more than three successive terms."

The proposed amendment is now pending before the House of Delegates, and your council will

conduct hearings at the time appointed during the 100th Annual Session, so that the views of all concerned may be expressed and considered for making recommendations for final action on the proposal. Your council notes that no incumbent Delegate to AMA would be affected by the amendment at the present annual session and that no departure from customary procedures in matters of this nature is necessary. Your council will also be prepared to consider any and all other proposed amendments which may be brought before the present annual session.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties. The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties, the Board shall have conducted eight meetings since the 99th Annual Session when this report is considered by the House of Delegates. The Board met in May, June, July, August, and December of 1967 and in February of 1968. Meetings are scheduled for April and May of 1968. This annual report includes actions on matters referred by the House of Delegates and those items relating to management and policy functions among the Board's responsibilities.

Referrals from the House of Delegates. Matters referred by the House of Delegates at the 99th Annual Session and actions by the House requiring consideration by the Board include:

(a) *Emergency Medical Care Unit.* The House of Delegates voted to continue the Emergency Medical Care Unit during regular and special sessions of the Legislature and asked that the Board restore the necessary funds to the annual budget for operation of the unit. The Board acted immediately to appropriate $3,000 for this purpose, and the unit was opened with the convening of the 1968 regular session. In keeping with the action of the House which recognized staffing difficulties in securing Doctors of the Day, the Board has called on all members to volunteer their services for one day in this activity. A registered professional nurse has been employed and is present in the unit during each legislative day.

(b) *Joint Billing of AMPAC and MPAC Dues.* At the request of the Mississippi Medical Political Action Committee, the House approved joint billing of PAC dues with annual membership dues by component medical societies of the association. This approval is conditional upon the billing statement clearly showing that PAC dues are voluntary and not deductible for tax purposes. This was formally communicated to each component medical society and was published in the JOURNAL. The Board is gratified with the response of the membership in this connection.

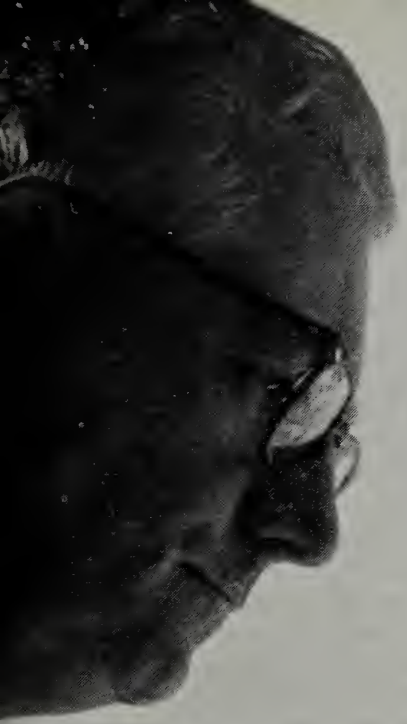
(c) *Resolution No. 3.* The House of Delegates adopted Resolution No. 3, subject: AMA Aims, introduced by the Delta Medical Society, at the 99th Annual Session. The AMA delegates introduced the resolution at the June 1967 annual convention of AMA at Atlantic City, and it was referred to the Board of Trustees. At the Houston clinical convention in 1967, the AMA Board recommended an 11-point statement of aims and purposes which greatly enlarged upon the previous declaration of purposes. In brief, the newer statement dedicates the skills and resources of the world's largest medical organization to a continuing effort to stimulate progress in all aspects of health care in America. The Board takes this opportunity to emphasize that the action of a single Mississippi component medical society has influenced the formulation and adoption of a major policy statement of the AMA.

(d) *MSMA Building.* The House of Delegates approved a proposed expansion of the association's Central Office Headquarters Building and gave the Board of Trustees necessary authority to construct the addition after consideration of bids and the awarding of contracts as has been done with the building in the past. A number of considerations prompted the Board to defer the construction project during the year, among which was the death of the architect. The need for increased space still exists, and the Board requests the House of Delegates to reconfirm the authority given in 1967 under the same stipulations and circumstances.

Association Insurance Programs. The Board of Trustees continues to monitor the various group insurance programs which have been made available to the membership. The Continental Casualty Co. of Chicago, through our state administrator, Thomas Yates and Co. of Jackson, offers seven categories of coverage including income replacement, life and 65, senior over-70 income supplement, catastrophic hospital plan, inhospital indemnity plan, senior Medicare supplement, and overhead expense plan. As many as 475 members per plan have purchased this coverage, and there are variations available under each category. The plans are stable, actuarially sound, and generally reflect a favorable experience. While the association is in no way engaged in the operation or administration of these plans, each is carefully monitored by the Board, and no contract revisions are made without the Board's approval.

Professional Liability Insurance. The St. Paul program which has been available to the member-





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Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported.

One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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ship since 1961 has directly influenced a premium reduction in Mississippi for this insurance of about 50 per cent. Despite the profound national trend of increasing premium rates for this essential coverage, the Mississippi program continues as one of the least expensive with a national ranking of 48th in cost. The membership is reminded, however, to purchase sufficient professional liability coverage and in the event of threatened or actually instituted litigation, to make use of review and advisory services which are available to all from the Board of Trustees. As with the Continental programs, the Board continually monitors the St. Paul program in detail as to written and earned premiums, rating structures, incurred losses, and loss ratio experience. At this reporting, 477 members have availed themselves of this coverage.

CHAMPUS Program. During 1967, the Civilian Health and Medical Program of the Uniformed Services, formerly known as the Dependents' Medical Care Program or the original Medicare, was substantially expanded with the implementation of Public Law 89-614 which included retirees and certain survivors. Additionally, outpatient services were authorized, subject to an annual deductible amount and a co-pay provision. Claims volume increased more than 400 per cent from the fall of 1967 through January of 1968, and it was necessary to double the staff in this department. Effective March 1, 1968, the association was successful in arranging a conversion from the former schedule of maximum allowances to payment of physicians' fees on a usual, customary, and prevailing basis. This concept, in effect, covers the 90 percentile in virtually every instance.

Regional Medical Program. The Mississippi Regional Medical Program has been established by the National Institutes of Health at the University Medical Center at Jackson. Dr. Guy D. Campbell of Jackson is the coordinator, and the region in which the program is operated has been defined to coincide with state boundaries. While the law under which these programs are developed specifically mentions heart disease, cancer, and stroke, the basic goal is to reduce any gaps between the potentialities of medical science and the realities of existing services and facilities.

Initial emphasis in the Mississippi program has been placed upon post-graduate medical education, a concept which the association supports. In this connection, our Council on Medical Education has conducted a comprehensive study, and the findings and recommendations are separately reported by the Board of Trustees.

During 1967, Dr. L. T. Carl of Jackson, who has represented the association as a member of the regional advisory group to the program resigned, and Dr. James L. Royals has been appointed to succeed him. The Board of Trustees regularly receives reports on the Mississippi program.

Blue Cross-Blue Shield Directors. On August 8, 1967, Dr. M. Q. Ewing, one of the 12 physician-directors of the Mississippi Hospital and Medical Service, Inc., died. The Board of Trustees nominated Dr. Stanley A. Hill of Corinth to succeed Dr. Ewing and to serve the unexpired portion of his term to 1969.

The Board has considered the custom observed in the selection of nominees for the Blue Cross-Blue Shield board of directors who are not contested on the ballot as is the case with all other officers for which the House of Delegates votes. The selection of nominees for these appointments is not prescribed in the By-Laws of the association. Believing that delegates should be able to express a choice, the Board believes that eight members should be proposed on the ballot by the Nominating Committee and that the four receiving the greatest number of votes be declared the nominees of the association for the posts due for appointment. The Board will separately make a proposal with reference to formalizing this procedure in the By-Laws.

Board of Trustees of Mental Institutions. Under the provisions of Section 6946-02, Chapter 3, Mississippi Code of 1942, Annotated, the association is obligated to submit nominations to the Governor of Mississippi from which he appoints physician-members of the Board of Trustees of Mental Institutions. The Board consists of two physicians and three members from the public at large, and terms are for six years each.

The association was informed that the term of Dr. James Grant Thompson of Jackson would expire on March 17, 1968, so the Board of Trustees of the state medical association, acting under the law, made the required five nominations to Governor John Bell Williams. The nominees were:

William B. Howard, Pontotoc
John E. Lindley, Meridian
Fred M. Sandifer, Jr., Greenwood
James Grant Thompson, Jackson
George M. Wilson, Gulfport

State Board of Health. At the 99th Annual Session in 1967, the House of Delegates made nominations for the State Board of Health for Public Health Districts 1 and 3, as prescribed by Section 7024, Mississippi Code of 1942, Annotated. The nominations were submitted to then-Governor Paul B. Johnson on May 29, 1967, and terms of the posts for which the nominations were made

expired on December 31, 1967. Governor Johnson did not act on the recommendations, and these were resubmitted to Governor Williams soon after his inauguration.

Fluoridation of Water Supplies. At the 93rd Annual Session in 1961, the House of Delegates approved fluoridation of water supplies in amounts not to exceed one part per million. The Mississippi Dental Association has recommended that "the Mississippi State Board of Health consider promulgating a statewide regulation concerning minimum standards for approval of public water supplies which include that the fluoride content be adjusted to the recommended level of one part per million," and the Board concurs in the proposal and has approved it.

Medicine and Religion. The Committee on Medicine and Religion has represented the association on two occasions at national meetings during the year, and the committee has acted in behalf of the association in cosponsoring the Seminar on Medicine and Religion at the University Medical Center March 14-15, 1968. The Board commends the committee for its work in this program and in conceiving the idea of the seminar. The Board notes with pride that His Excellency, the Most Reverend Joseph B. Brunini of Jackson, Bishop of the Diocese of Mississippi, has been appointed a member of the AMA Committee on Medicine and Religion.

Journal MSMA. Our JOURNAL, now in its ninth year, enjoyed its second best year in advertising revenues during 1967. Of greater importance has been the increase in the quality of scientific papers and Mississippi medical news regularly published in the JOURNAL. The recently adopted regulations of the U. S. Internal Revenue Service which tax so-called unrelated income from scientific publications of exempt organizations have been carefully reviewed by the Board. We have asked our certified public accountants to work closely with the executive staff in assigning all lawful charges against such revenues. The Board warmly commends the Committee on Publications and the Editors for their services to the scientific work of the association and for their continued successes in this, the largest single association-owned and sponsored project.

Organization of the Board. Three new members of the Board were welcomed during the association year. Drs. John M. Alford, Jr., of Greenwood and James O. Gilmore of Oxford were seated as regularly elected Trustees for Districts 1 and 2, respectively. Dr. G. Swink Hicks of Natchez, the District 8 Trustee, resigned effective December 7, 1967, to assume his new duties as Delegate to the American Medical Association. He further serves as a member of the State Board of Health and as a director of the Mississippi Hospital and Medical Service, Inc. Dr. Everett Crawford of Tylertown was appointed by the president to serve Dr. Hicks' unexpired term.

The president, president-elect, secretary-treasurer, speaker, vice speaker, and AMA delegates sit with the Board in all meetings. Officers of the Board of Trustees during 1967-1968 are Drs. John B. Howell, Jr., chairman; Lamar Arrington, vice chairman; and C. D. Taylor, Jr., secretary.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties. The Council on Medical Service is a constitutional body of the House of Delegates. It is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under its jurisdiction there are assigned the activities of the association in medical service, emergency service programs, indigent care and allied medical agencies. The council is assisted in its work by three constitutional committees and three *ad hoc* committees. Programs, studies and activities of the council's several committees during the 1967-68 association year embraced a wide range of subject areas and policy development. These were:

Committee on Maternal and Child Care. This committee has the responsibility of studying every maternal death occurring in the state. Meaningful postgraduate education in maternal and child care is the goal of the committee's activities. During the past year the committee, following the AMA's *Guide for Maternal Death Studies,* reviewed and evaluated 28 maternal deaths occurring in the state. Each attending physician in these cases was confidentially informed of the committee's findings. As of February, 1968, the committee had sent out 533 inquiries on maternal deaths since its study began in January, 1957. Replies have been received in 441 or 82.7 per cent of these cases.

As its major postgraduate education project this year, the committee has developed a set of Maternal and Child Care Desk Cards and distributed them to all hospitals in the state for use in OB care. The cards are concerned with outlining care for the difficult OB situation. They will also be distributed to interested physicians and other groups in the state. Supplementary to its studies, the committee has presented the following scientific paper in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION: "Case Report XIII of Maternal Mortality Study," July, 1967.

The committee has also continued to reduce its study data to IBM and adjunctive to this project, the committee will prepare articles for publication

in the JOURNAL MSMA this year which are based upon its maternal mortality IBM data. A scientific exhibit based upon this data is also being considered as a committee project for presentation at society and annual meetings of the association and before other interested groups.

Committee on Occupational Health. This committee has responsibility for studying all aspects of occupational health in Mississippi. Following up on the preparation and presentation of its study and report, "Occupational Health Programs in Small Plants in Mississippi," to the House of Delegates last year, a major paper was prepared on this project and presented by the committee's chairman before the 27th Congress on Occupational Health sponsored by the American Medical Association. The committee's report has been requested and distributed on both the national and state level. The Mississippi Manufacturers' Association has distributed the report to all its members.

Members of the committee are preparing a series of articles concerning various subjects in the field of occupational health for publication in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION. The first article titled "Workmen's Compensation Forms" appeared in the August, 1967, issue of the JOURNAL. Based upon previous authorities granted by the House of Delegates, the committee will work this year towards preparing a guide for occupational health programs in small plants in Mississippi, and it is anticipated that this project will be the subject of a major report to the House of Delegates at next year's annual meeting.

Committee on Mental Health. This committee has responsibility in the broad field of mental health activities. The problem of drug control and abuse has recently become a subject of serious concern in the state, and the chairman of the committee has met with a group composed of interested authorities in this connection. The chairman of the committee also attended the 14th Annual Conference of State Medical Society Mental Health Representatives sponsored by the AMA in Chicago, March 15-16, 1968. Drug abuse was the primary topic of this important conference.

Committee on Nursing (ad hoc). This committee has responsibility for conducting a program of active liaison with the Mississippi Nurses' Association. During the past year the chairman of the committee attended the AMA's first special conference on nursing in Chicago, October 6, 1967. Three subject areas have been proposed for consideration by the committee and its counterpart from the Mississippi Nurses' Association—i.e., mandatory licensure of nurses; the future role of the hospital diploma school; and programs to reclaim the retired nurse. An early summer meeting will be held in this connection.

Health Insurance Benefits Advisory Committee (ad hoc). This committee was established by the council to act as a fact-finding and advisory committee on professional problems that might arise with respect to the operation of the Medicare Program in Mississippi. Among public and private agencies in Mississippi the committee met with last year was the Medicare Unit of the Mississippi State Board of Health which serves as certifying agency for providers of care in Mississippi under Medicare. This agency desires and requires a professional advisory committee of practicing physicians and has requested that the association's Health Insurance Benefits Advisory Committee serve in this capacity. Your council approves and commends this request. The committee will additionally continue to serve as a fact-finding body on Medicare and your council again urges the membership to contact the committee when problems are encountered in this regard.

Committee on Blood and Blood Banking (ad hoc). This committee has responsibility for monitoring all aspects of blood banking and transfusion service and professional and socio-economic policy in this regard. At the association's 99th Annual Session, the committee reported on establishment of a blood and blood plasma program at the Mississippi Penitentiary at Parchman and was urged by the House of Delegates to closely monitor the program and report on its operation. In this connection, the committee made its first on-site inspection of the finalized program this year. A special report was presented by the committee in the February 1968 issue of the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, and the committee stated in this regard that it "is favorably impressed with the permanent facility which has been constructed (at Parchman), with the personnel, the direction of the program, and with the overall beneficial effect on the situation. . . ."

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties. The Council on Scientific Assembly is a constitutional body of the House of Delegates. It is charged with the responsibility of planning the annual sessions of the association to include all scientific activity and the programming and scheduling of annual session events. The council membership consists of the chairmen and secretaries of the several scientific sections and the secretary-treasurer of the association.

100th Annual Session. This annual session marks the centennial meeting of the association, although the association was founded in 1856. Your council believes that the scientific format planned for this meeting represents a fitting memorial to 100 years of postgraduate medical education in Mississippi and a significant preview of the next 100 years in this vital area of professional interest and endeavor. With the valued support and co-operation of the Medical Television Department of Smith Kline and French Laboratories and the University of Mississippi School of Medicine, your council has scheduled live, color television presentations as a significant portion of the scientific program at this annual meeting. This event has required the time and effort of individuals too numerous to mention in this report. Your council expresses appreciation to all involved and especially to the color television program chairman, Dr. William O. Barnett, and the several television moderators, Drs. George D. Purvis, J. Harvey Johnston, James L. Royals, Robert D. Currier, Herbert G. Langford and James Grant Thompson.

Scientific Film Program. At the 99th Annual Session, your council initiated a program of scientific films to precede each section meeting. These several programs were well received and your council, therefore, continued the scientific film program for this meeting. An effort has again been made to co-ordinate this portion of each section with the live scientific program to follow. Your council acknowledges with appreciation the work of its film program chairman, Dr. Calvin T. Hull.

Ainsworth Resolution. At the 93rd Annual Session, 1961, the House of Delegates implemented a resolution introduced by Dr. Temple Ainsworth calling on the several scientific sections of the association to confer with specialty society representatives from the fields of orthopaedic surgery, neurosurgery, anesthesiology, pathology, radiology and urology towards placing papers before the several sections from these specialties. Following up on this resolution, your council has written the officers of specialty societies in these several medical disciplines prior to each annual session urging requests for program time. On many occasions such requests have been made and essayists have appeared before the scientific sections from these specialties. On several occasions, however, requests for time have been received subsequent to the formalizing of section programs. In this regard, your council would like to take this opportunity to urge early requests for such time even to the extent of contacting the section officers concerned at this annual meeting if program time is desired at the 101st Annual Session to be conducted in 1969.

Financing Annual Meetings. The association sponsored activities of our annual meetings, as with similar medical meetings, are financed entirely by sales of exhibit space except for the annual association party. This is in contrast to association meetings which are financed entirely or in great part by registration fees. Although we have been fortunate in the degree of supportive continuity shown by pharmaceutical companies in our annual meetings, and your council foresees no immediate drastic change in this trend, it should be noted that numerous medical meetings are experiencing a definite problem in this regard. The council wishes the House of Delegates to be aware of this situation and assures you that it will receive our continued observation so that alternatives to present financing mechanisms may be proposed if necessary.

Specialty Society Meetings. Your council is happy to report that sixteen specialty and other medical groups will meet concurrently with this annual session of the association. This combination of meetings benefits all groups involved in competing for the time of the busy physician, and your council urges the support of the House of Delegates in encouraging a fuller implementation of this annual meeting concept.

Scheduling of Annual Sessions. At the 98th Annual Session, this House of Delegates, on recommendation of the council, adopted a four year advance schedule of annual sessions. At the 99th Annual Session this House of Delegates, again on recommendation of the council, agreed to hold all future annual sessions on the Gulf Coast after the 1968 meeting in Jackson. A basic factor in this recommendation was the decline in convention facilities in Jackson compared to the continued improvement of facilities on the Coast.

The matter has become even more acute in Jackson, and your council wishes to note that it has experienced tremendous difficulties in finding adequate meeting space for the various functions conducted during this annual session. There is no indication that this situation will improve in the immediate future and your council, therefore, especially recommends that the House of Delegates continue to pursue its course of holding all future annual meetings on the Gulf Coast.

Expression of the Council. Planning and organization of this annual session began with a meeting of the council on August 2 of last year. Your council is grateful for the support, assistance, and co-operation it has received from all concerned with this meeting. We trust that the 100th Annual Session will be professionally profitable and personally enjoyable to all.

University Board Accredits Nursing Schools

The Board of Trustees of Institutions of Higher Learning has announced that 17 nurse training programs in Mississippi have been accredited for the calendar year 1968. These include two baccalaureate degree programs, five hospital diploma training schools, and 10 associate degree programs conducted in junior colleges and other institutions of higher learning.

The full degree programs are at the University of Mississippi's School of Nursing at Jackson and the University of Southern Mississippi's School of Nursing at Hattiesburg.

The five hospital diploma schools are conducted by the Matty Hersee Hospital at Meridian, the Mercy Hospital-Street Memorial at Vicksburg, the Methodist Hospital at Hattiesburg, and two Jackson institutions, the Mississippi Baptist and St. Dominic-Jackson Memorial hospitals.

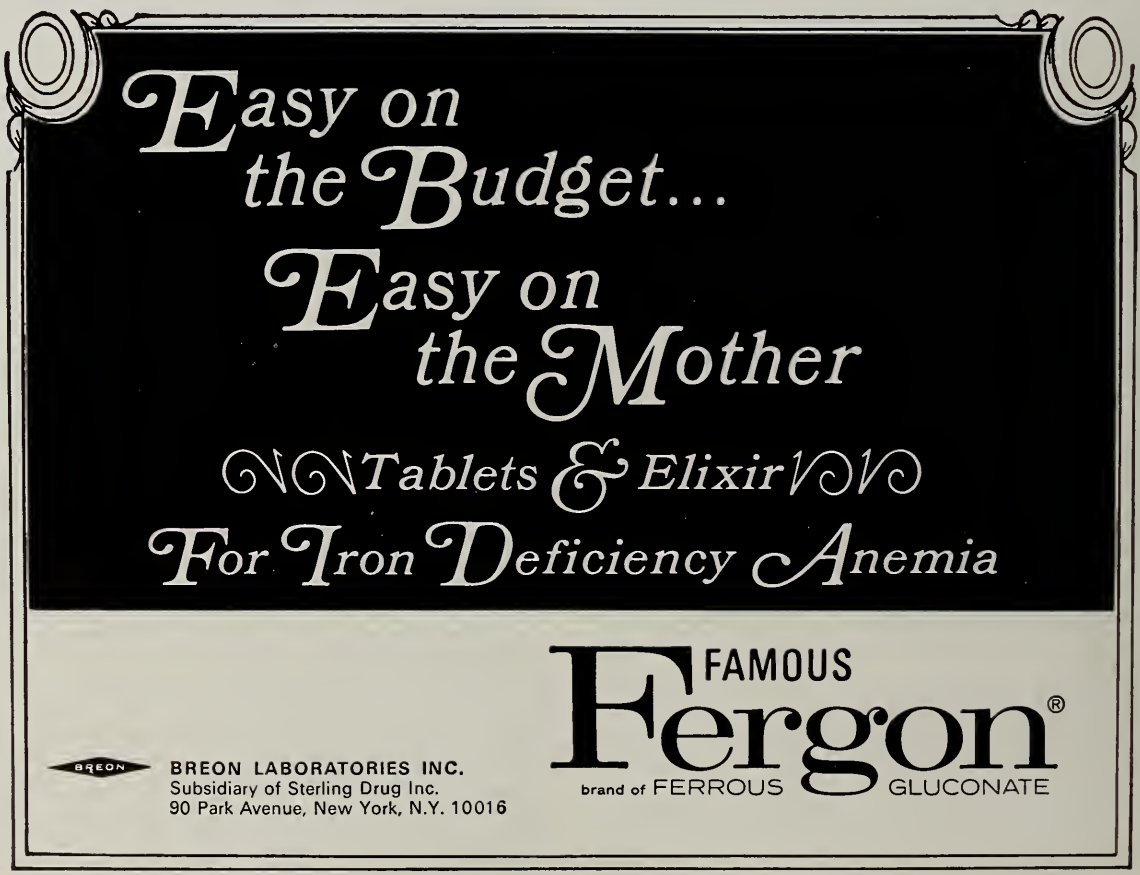
Associate degree programs are part of junior college curricula at Handsboro, Gautier, Raymond, Ellisville, Meridian, Moorhead, Poplarville, and Booneville. Other associate degree programs are conducted by Mississippi Valley State College at Itta Bena and by the University of Southern Mississippi at its Natchez Resident Center.

Former Faculty Return To Medical Center

Two former faculty members are returning to the University of Mississippi School of Medicine, effective March 1. They are Dr. Roger B. Arhelger, associate professor of pathology, and Dr. Kentaro Koshino, assistant professor of neurosurgery (research).

Dr. Arhelger, who comes from a position at the University of South Texas Medical College in San Antonio, was at the Medical Center from 1962 to 1966. He also took residency training at the Medical Center. Dr. Arhelger earned the M.D. degree at the University of Minnesota Medical School and did his internship at the U.S.P.H.S. Hospital in Boston.

Dr. Koshino was at the Medical Center from 1964 to 1967. A graduate of the Osaka University Medical School in Japan, he holds both the M.D. and Ph.D. degrees. He interned and took residency training at Osaka University Hospital. He has served as visiting investigator at Tulane University.



SSA Moves To Economy in Medicare

Following the directive in the President's Health Message, Robert M. Ball, Commissioner of Social Security, has announced the beginning of an experimental program to find methods of reimbursing hospitals and doctors that will have built-in incentives to efficiency and economy.

"The experiments," the Social Security Commissioner said, "are expected to develop ways to get more value for the dollar spent on health care and will be applicable in reimbursing hospitals and doctors under medicare and other Federal health programs."

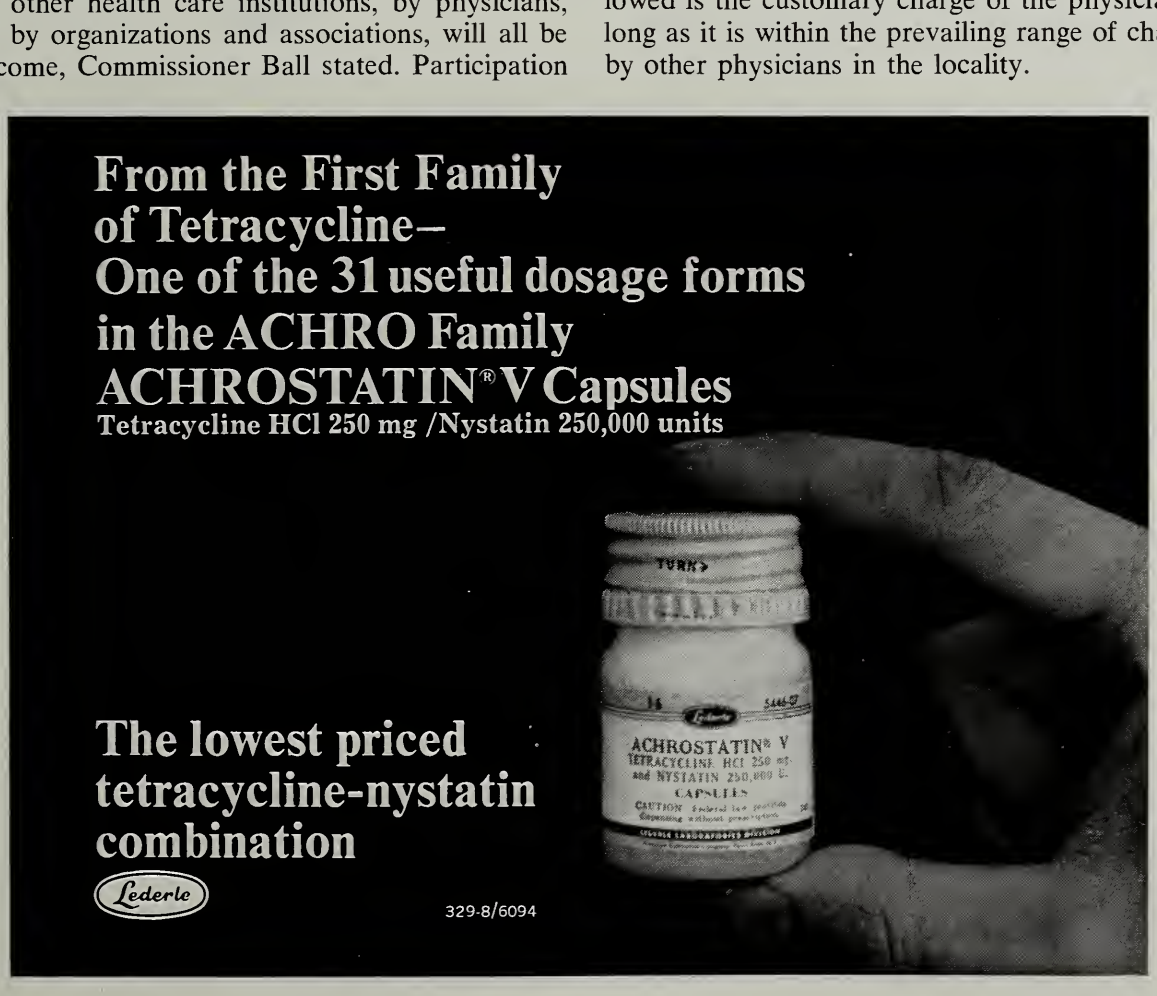
The purpose of the experiments, the Social Security Commissioner said, is to find methods of reimbursement that will provide incentives to efficiency and economy, and at the same time maintain a high level of quality care. The medicaid and maternal and child health programs financed by Federal-State expenditures, as well as the medicare program, will be involved in some of the experiments.

Participation in the experiments by hospitals and other health care institutions, by physicians, and by organizations and associations, will all be welcome, Commissioner Ball stated. Participation is entirely voluntary. Proposals will be evaluated by a panel of experts and the best selected for experimentation.

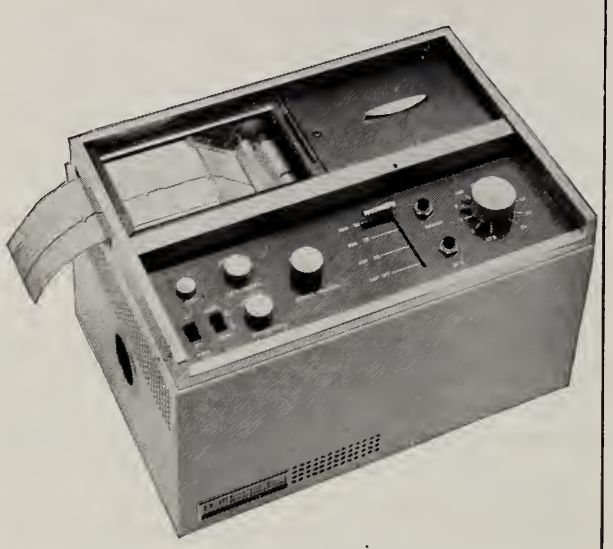
Participation by governmental organizations and by nongovernmental organizations, such as Blue Cross and Blue Shield plans, group practice prepayment plans, labor management plans, union clinics, and private health insurance organizations which pay for health services as well as proposals from providers themselves will be advantageous, Commissioner Ball noted. The experiments that turn out favorably, he said, may benefit the entire health care system, private as well as governmental.

Under the medicare law, Commissioner Ball said, hospitals and other institutional providers of medicare services are reimbursed for their reasonable costs under a national reimbursement formula which provides guidelines as to which costs are allowable. The formula has been criticized on the ground that it provides no special incentives for economy and efficiency.

Reimbursement to physicians for services provided medicare beneficiaries is made by insurance carriers under Government contract on the basis of reasonable charges—generally the charge allowed is the customary charge of the physician as long as it is within the prevailing range of charges by other physicians in the locality.



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Dr. Walkinshaw Gets NIH Research Grant

A $15,776 research career development award from the National Institute of General Medical Sciences is supporting Dr. Charles H. Walkinshaw, Jr., assistant professor of microbiology at the University Medical Center, as he continues his studies of the synthetic capacity of fungal cells and their organelles.

The award was given Dr. Walkinshaw in national competition following review by two groups of consultants. By studying the regulation of cell protein production, Dr. Walkinshaw hopes to learn basic knowledge which may lead to medical progress.

Because cell proteins are believed to play an important role in infection, he thinks that better understanding of fungal cells and their metabolism might eventually provide information regarding improved methods of treating and controlling fungus diseases.

Rocky's 'Medicare' Causes Furor in N.Y.

Governor Nelson A. Rockefeller's universal compulsory medical care program for all New Yorkers is causing a furor at Albany, as committees of the legislature conduct hearings on the tax-supported program. As proposed, the program would apply to every employer with one employee, except for domestic workers.

Gov. Rockefeller said that small employers are particular targets for the program which has also been endorsed by State Health Officer Hollis S. Ingram.

Confusion is resulting from misunderstanding over 120 days of hospitalization and whether it would be allowed per spell of illness or per year. In addition, the plan calls for 100 days of home care following hospitalization, inpatient and outpatient physicians' services, and $150 in maternity benefits. While the home care aspect provides for visiting nurses, care in a nursing home is excluded. All in all, the program is more generous than Medicare.

Financing would be by compulsory, employment-related taxation on employer and employee. Where an employer sponsors a plan for employees which meets or exceeds the state program, the employer would be exempt from the law as long as he maintains his program.



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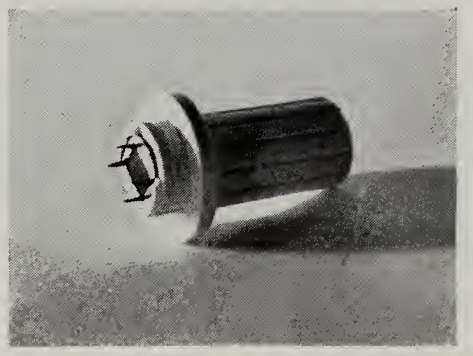
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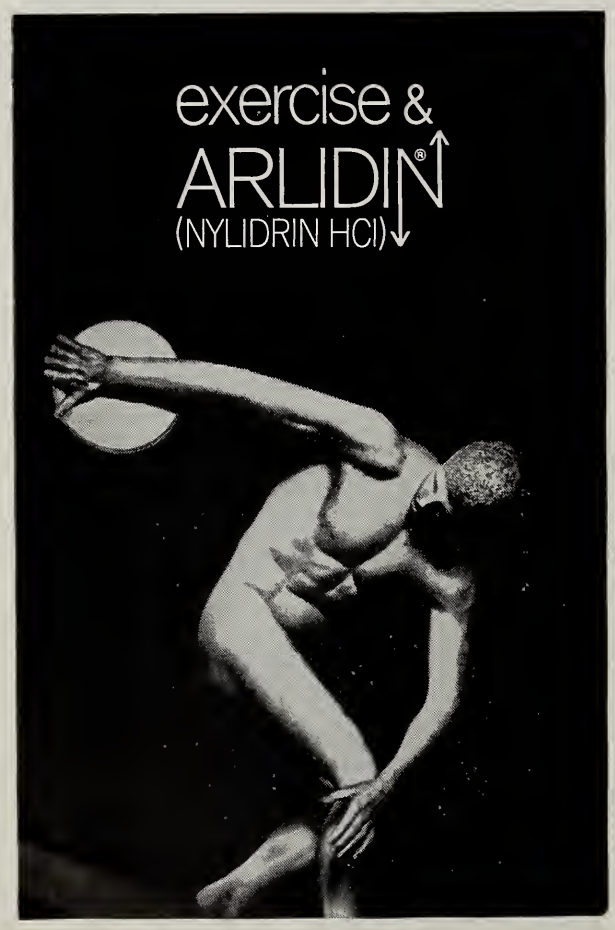


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Lederle Awards Grants To Medical Professors

Twelve medical school faculty members, including a UMC member, were awarded grants by Lederle Laboratories for their dedication to medical teaching. They will share a total of $250,000.

The Lederle Medical Faculty Awards—established 15 years ago—are made annually to maintain the high caliber of medical education and to encourage medical teachers and investigators to remain in their disciplines. Today, there is an estimated shortage of nearly 1,400 full-time teachers in the 103 U. S. medical schools.

Lederle has given nearly $9 million in the support of medical education, of which more than $4 million has been allocated to 216 faculty members.

This year's recipients include: Dr. W. Grady Smith, University of Arkansas; Dr. Jared M. Diamond, University of California, Los Angeles; Dr. Anthony P. Monaco, Harvard Medical School; Dr. Milton Diamond, University of Hawaii; Dr. Barnard Weiss, Johns Hopkins University; Dr. Joseph Wells, University of Maryland.

Dr. Aubrey E. Taylor, University of Mississippi; Dr. T. John Leppi, University of New Mexico; Dr. Ronald L. St. Pierre, Ohio State University; Dr. Steven Keresztes-Nagy, Stritch School of Medicine, Chicago; Dr. Jeanne Marie Lusher, Tulane University; Dr. Paul Bornstein, University of Washington.

The awardees are selected by an independent committee composed of seven leading medical educators who have full authority for selecting the recipients. Chairman of the committee is Dr. Maxwell Finland, who is George Richards Minot Professor of Medicine at Harvard Medical School.

UMC Schedules 1968 Commencement

The University of Mississippi Medical Center will hold its twelfth annual Commencement June 2 at 4 p.m. in the Jackson Municipal Auditorium with Dr. E. R. Jobe, executive secretary and director of the Mississippi Board of Trustees of Institutions of Higher Learning, as speaker.

Chancellor Porter Fortune will confer degrees on graduates of the School of Medicine, the School of Nursing and graduate studies in the health sciences.

NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

May 1968

Dear Doctor:

The New York state legislature has just defeated a bill requiring hospitals to have a physician on 24-hour duty for emergency room service. Measure was similar to House Bill 639 in the Mississippi Legislature which would apply to hospitals with 100 or more beds. There are 22 such institutions in state.

> HB 639 has teeth in it that would prohibit receipt of public funds by hospitals failing to comply with requirement. Bill has a majority of members of House of Representatives as co-sponsors, and it originated with House members from Harrison County.

The Bureau of Narcotics has been transferred to the Department of Justice from the Treasury Department by President Johnson. The Bureau was created in 1914 with passage of the Harrison Act when first controls over narcotic drugs were instituted. The reorganized unit will also control "dangerous drugs" and have an educational function.

Mississippi State Board of Health has announced a grant of $54,000 for an adult vision conservation program for seven Delta counties. Headquartered at Greenville, the program will be conducted with cooperation of the Department of Ophthalmology of UMC, ophthalmologists in private practice, and State Department of Public Welfare. County health departments will also participate in screening.

Part 1-B of Medicare in Mississippi continues to show a heavy volume of claims and rate of payments, according to Travelers' administrator. Nearly 54,000 claims were processed during first quarter of 1968 with payments of more than $2.3 million. Trend in April, for which figures are not yet available, shows notable increase.

All roads lead to Jackson for the association's 100th Annual Session in less than two weeks, May 13-16. Headquarters for scientific and business sessions are Hotel Heidelberg. Big feature of scientific program is closed circuit color television, live from University Medical Center. Hurry and make reservations.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Cohen Shakes Up HEW Health Activities

Washington - The Surgeon General of the U.S. and the Food and Drug Commissioner are no longer their own bosses, under a Department of HEW shake-up ordered by new Secretary Wilbur J. Cohen. Each has been placed under Assistant Secretary Philip R. Lee. Cohen said at first news conference that health care will someday run 50 per cent of total welfare costs and that he does not believe private programs can be sufficiently improved to eliminate need for government help.

Physicians Take Advice Against Smoking Seriously

Chicago - AMA reports survey figures showing that 100,000 American physicians have stopped smoking cigarettes. About 35 per cent have never smoked, 36 per cent have quit cold, and only 29 per cent are still smoking. By contrast, according to USPHS figures, 52 per cent of American adult male population and 34 per cent of females currently smoke cigarettes. Surgeon General William H. Stewart has commended medical profession for setting example for public.

Travel Boom Encourages New Health Insurance

New York - More than 150,000 Americans went overseas during April, a 20 per cent increase over April of 1967, and many had a new temporary insurance package which included health benefits. Health Insurance Institute says for about $20 premium, package coverage can be obtained providing $1,500 in health care benefits, $15,000 death benefit, and $500 baggage loss for a period of 30 days. For over-65 travelers, HII emphasized that Medicare doesn't pay outside U.S. except for emergencies on Canadian and Mexican borders.

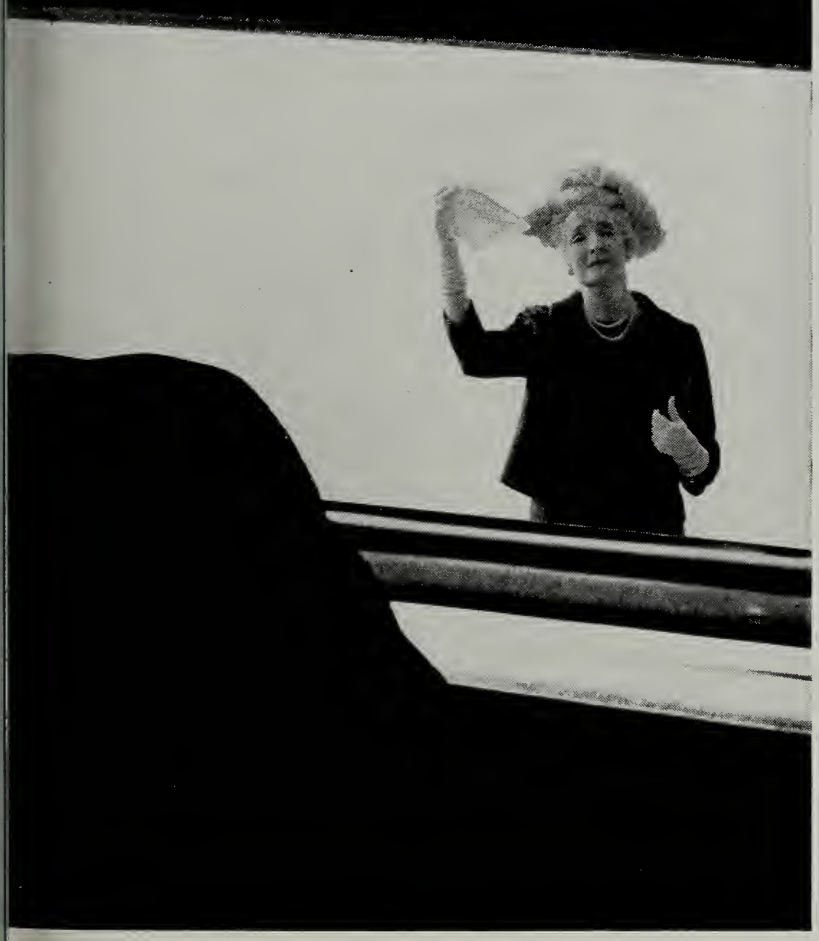
MCAT Examinees Show Increase

Evanston, Ill. - The Association of American Medical Colleges reports that more than 22,000 students took the Medical College Admission Test in 1967, well up over the 18,000 examinees in 1966. One out of 10 was a woman, and nearly half were college juniors. About 3,000 were in southwestern U.S., an area from Alabama to Texas, while a third were in New England-New York area. AAMC says there will be about 9,500 openings in U.S. medical schools this fall for entering students.

Medicare Hospital 'Reserve' Is Optional

Baltimore - The Social Security Administration has held that the 60-day lifetime reserve for hospital care beyond 90-day regular inpatient period may or may not be used at the option of the patient when any stay goes beyond three months. Ruling is noted to take supplemental private coverage into consideration, against a time when reserve is needed.

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Hearing Aid Makers Give to HOPE Mission

Hearing aids, diagnostic equipment and accessories valued at nearly $50,000 were placed aboard the hospital ship HOPE as she prepared to sail for her 10-month visit to Ceylon. The hundreds of items of hearing equipment were a gift from the hearing aid dealers and manufacturers of America.

Raymond Z. Rich, president of the National Hearing Aid Society, and Samuel F. Lybarger, Hearing Aid Industry Conference president, presented the instruments and accessories to Dr. William B. Walsh, founder and president of Project HOPE and Ambassador Oliver Weerasinghe of Ceylon, during farewell ceremonies. The ship will arrive at Columbo, Ceylon, in mid-April.

Rich is president of Radioear Hearing Aid Service of Cleveland, Ohio, and Lybarger executive vice president of Radioear Corporation of Canonsburg, Pennsylvania.

"Loss of hearing is the most common physical impairment," said Lybarger, spokesman for the hearing aid manufacturers. "It gives us real pleasure to join in this great force of progress that HOPE has created. We are confident that our efforts in cooperation with Project HOPE will be of value in educational, diagnostic and therapeutic activities of HOPE in Ceylon."

Nearly 200 hearing aids, hundreds of spare batteries and other accessories, an auditory training unit, earmold materials, and special test and teaching devices are among the equipment donated by the dealers and manufacturers.

Anton P. Mynders, president of Medical Acoustical Instrument Co. of Pennsylvania (Philadelphia), headed the industry campaign to collect hearing aids and accessories from manufacturers across the country.

Mynders' company and Koch Laboratories in Philadelphia, serviced, repaired and reinstalled all of HOPE's present auditory equipment while it was berthed at a Chester, Pa., shipyard.

Color TV Films Highlight AMA Meet

Approximately 50 medical motion pictures will be shown as part of the scientific program at the 117th Annual Convention of the American Medical Association in San Francisco, June 16-20.

Color television, presented live from a San

Francisco-area medical facility, also will be featured.

The medical motion picture program will include the premiere of a new film on Diagnosis of Heart Disease, made with the sponsorship of the American College of Cardiology. Narrator of the film is Dr. Tinsley Harrison, Distinguished Professor of Medicine, University of Alabama, an internationally known authority on diagnosis of the causes of cardiac pain.

Other films to be included: Radiographic Visualization of the Biliary System and Cholecystectomy and Choledochotomy, by Dr. Frank Glenn; Bullet Embolus of the Right Ventricle, by Arthur Beall; Role of the Endometrium in Conception and Menstruation, by Dr. John Rock; and, Cold Light Endoscopy, by Norman P. Schenker of Munich, Germany, an award-winning film made in France, Germany and Austria for U.S. physicians.

Five Scientific Sections are to present programs on color television: Dermatology, case presentations; General Surgery, a surgical program including live telecast of an operation, moderated by J. Englebert Dunphy, Professor of Surgery, University of California; Laryngology, Otology and Rhinology, a program on sinus diseases; Obstetrics and Gynecology, the complete gynecologic examination; Orthopedic Surgery, spine problems in children.

The entire Scientific Program for the 1968 Annual Convention will be published in the May 6 issue of the *Journal of the American Medical Association.*

Ole Miss Student Wins SKF Grant

A junior at the University of Mississippi School of Medicine is among 31 American medical students selected to receive a Smith Kline and French Foreign Fellowship from the Association of American Medical Colleges.

Alan H. Mumm of Galesburg, Ill., has been awarded a $1,415 fellowship which will permit him to work for 12 weeks this summer at Buriram Hospital in Thailand. A magna cum laude graduate of Auburn University, Mumm is the third of the University's medical students to receive a Smith Kline and French Fellowship since the program was established nine years ago.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Primary Malignant Osseous And Soft Tissue Tumors

PAUL S. DERIAN, M.D., and DONALD E. COOK, M.D.
Jackson, Mississippi

During the period 1956 to 1966, 68 patients with a diagnosis of malignant bone or soft tissue tumors were reviewed at the University of Mississippi Medical Center. Thirty-three of these cases were selected for study. The authors report this study and conclude that a representative tissue diagnosis (frozen section) and surgery that removes the lesion provide the best results.

SIXTY-EIGHT patients with a diagnosis of malignant bone or soft tissue tumors were reviewed at the University of Mississippi Medical Center from 1956 to 1966. Of these, 33 cases were selected for study. The remainder, 35, could not be considered for the following reasons:

1. inadequate follow-ups
2. lack of or conflict of a specific tissue diagnosis
3. patients could not be located
4. reluctance on the part of the patient to participate in the study
5. lost records
6. pertinent x-rays removed from master jackets
7. pathology slides could not be located

The loss of 55 per cent of tumor-patient data is appalling. Valuable and irreplaceable material for any study warrants care in the make-up and handling of the hospital charts.

Only the unquestionable cases were included. The authors felt that to thoroughly evaluate a selected group of malignant tumors would add to the literature. Secondary chondrosarcomas were excluded. Prior to 1960, arteriograms and radioactive assessments were not part of the study task. After this time, inclusion of such studies proved to be of limited advantage in establishing a directed diagnosis prior to surgery.

In Table I, 11 patients with a diagnosis of osteosarcoma were evaluated. The average age at time of diagnosis was 17.6 years; the duration of symptoms was three months. The primary site was the distal femur in seven patients and proximal tibia in two. One was diagnosed at time of thoracotomy. The primary site could not be located, and the tissue specimen was obtained from the metastatic area in the lung. The last involved the proximal humerus. Three patients had pulmonary metastasis at the time of diagnosis.

Four of the 11 have survived over two years.

From the Department of Orthopedic Surgery, University of Mississippi School of Medicine.

One is five and a half years and three are two years postoperative with no evidence of local recurrence or pulmonary metastasis.

The term "osteogenic sarcoma" applies to a bone-forming tumor with metaplastic tissue characterized by bone destruction, increased vascularity, and ossification. It is the most frequently encountered primary malignant tumor of bone. The osteosarcoma usually begins in the metaphysis of long bones with irritation of the periosteum. Bony "feathers" (amorphous) are formed from 45 to 90 degrees to the shaft. The x-ray pattern is that of "wispy" flaking of bone rather than true opacity seen with normal bone. The term "sun burst" is often used. A slight hyperthermia and leukocytosis may be present. (Not pathonomic of malignant bone tumors.)

Clinically, an osteocarcoma is characterized by constant unremitting pain and swelling in the tumor region. The duration of symptoms is from 3 to 12 months with an increase in severity after the initial 3 months' time.

Most patients with an osteosarcoma are between the ages of 15 and 25. Over 80 per cent of the tumors are situated in either the distal femur or proximal tibia (about the knee). Trauma may initiate the symptomatology in 50 to 60 per cent of the patients. Whether it represents the causative agent is doubtful. It attracts the physician to the site. A pathological fracture is unusual in contrast to metastatic tumors and only occurs in about 7 to 10 per cent of all extremity malignant tumors.

Lichtenstein stated that the essential criteria for diagnosis of an osteosarcoma is:

1. presence of frankly sarcomatous stroma
2. direct formation of tumorous osteoid and bone by this malignant connective tissue

The osteoblasts are packed closely into the osteoid material and show large binucleated malignant types. No semblance of normal tissue patterns is present.

Table II is of 952 reviewed osteosarcomas showing an overall 5-year survival rate of 16.5 per cent. Four of the 11 patients (36 per cent) at the University of Mississippi Medical Center have a limited (two years and nine months) noncomparable survival.

Operative technique in these cases calls for a tourniquet to be placed proximal to the lesion after anesthesia. Generally, the two-tourniquet technique is not practical as the tumor is often of sufficient size to mechanically limit two-tourniquet use. This is not true with a tibial mass, but is obvious in a femur lesion. Whenever possible, the joint above the involved bone should be part of the amputation (2 to 3 per cent of malignant tumors have "skip areas" in a single bone).

TABLE I

OSTEOGENIC SARCOMA

Age	*Race*	*Sex*	*Duration of Symptoms*	*Metastasis at Time of Diagnosis*	*Location of Primary*	*Treatment*	*Results*
14	W	F	1 month	None	Proximal tibia	Radical en bloc excision	Expired 7 months
8	N	M	4 days	None	Distal femur	Hip disarticulation	Expired 4 months
14	N	M	4 months	None	Distal femur	Preop.—Radiation. High A/K amputation	Expired 3 months
16	N	M	6 months	None	Proximal tibia	High A/K; postop.—antimetabolites	Expired 8 months
18	W	M	4 months	None	Distal femur	Pre- and postop.—Cytoxan, high A/K	5½-years survival
12	N	F	2 weeks	Pulmonary	Distal femur	Pre- and postop.—Cytoxan, high A/K	Expired 2 months
16	N	M	6 months	Pulmonary	Distal femur	Cytoxan. No surgery	Expired 2 months
46	N	M	6 weeks	Pulmonary	Unknown	Supportive care	Expired 4 months
16	N	M	6 weeks	None	Distal femur	Hip disarticulation	Alive 2 years postop.
16	N	F	3 months	None	Distal femur	Hip disarticulation	Alive 2 years without metastasis
17	W	M	3 months	None	Prox. humerus	Forequarter	Alive 2 years without metastasis

TABLE II

Author	Number of Patients	Percentage—5-Year Survival
Lichtenstein	25	8.0
Coley	201	10.9
Geschicter and Copeland	121	15.7
	147	21.8
Tracey	13	15.4
Weinfield	92	14.1
Coventry	353	19.3
Total Patients—952	Overall % 5-yr. survival—16.5%	

There was no correlation between the amount of osteoid formation and survival. Grading of the osteosarcomas was not possible. The cure probability-ratio deceases as the duration of symptoms increases. Furthermore, the probability of a cure is reduced by preliminary biopsy and delayed ablation that are still being done.

There were 10 patients with fibrosarcoma (Table III). The average age at time of diagnosis was 38 years, 20 years older than the patient group with osteosarcomas. Average duration of symptoms was seven months; four months longer than the 11 patients with osteosarcomas. Six patients had no evidence of metastasis at the time of biopsy. Three patients expired within 18 months, two developed local recurrence, and two had pulmonary metastasis within two years. Three patients are alive—two, four, and five years post-surgery—without any evidence of local recurrence or pulmonary metastasis.

Basically, a fibrosarcoma of bone is defined as a primary fibroblastic tumor exhibiting no tendency to form osteoid or bone. There are a variety of histological patterns. The age is higher than that of the osteosarcoma group. Constant pain and swelling are the presenting symptoms. It is a slow-growing tumor with a tendency to recur after local excision. Fibrosarcomas can be classified as being poor or well, depending on the anaplasia.

The x-ray appearance of a fibrosarcoma is radiolucent. New bone formation does not generally occur. The location of the lesion is about the knee in the metaphyseal areas of the tibia and femur.

Microscopically, the fibroblasts are long and spindle-shaped; there is elongation of the nucleus. Anaplasia is proporational to the specific type of tumor. In the poorly differentiated type there is increased cellularity, pleomorphic appearance of the cells, and the presence of multiple nuclei.

An analysis of 31 patients of two surveys in Table IV shows a five-year survival rate of 38.7 per cent. At the University of Mississippi Medical Center, there were three patients or 30 per cent

TABLE III

FIBROSARCOMAS OF EXTREMITIES

Age	Race	Sex	Duration of Symptoms	Location of Primary	Metastasis	Treatment	Results
16	N	M	2 months	Rib	Pulmonary	Radiation	Expired 7 months
53	W	M	6 months	Ilium	None	Radiation and hemipelvectomy	Expired 16 months
61	W	F	6 months	Right forearm	None	Local excision	Local recurrence 7 months
23	N	F	5 months	Right supra-clavicular area	Regional resection	5 FUDR	Alive 5 years without recurrence
26	W	F	8 months	Finger	None	B/E amputation	Alive 2 years without recurrence
46	N	F	19 months	Left heel	None	B/K amputation. Cytoxan	Pulmonary metastasis in 1 year
49	N	M	9 months	Left groin	Local recurrence	Perfusion Cytoxan	Expired 12 months
42	W	M	6 months	Left forearm	None	Excision	Local recurrence 2 years
65	N	F	6 months	Left thigh	Axilla	5 FUDR and Alkeran	Pulmonary metastasis 1 year
15	W	M	3 months	Left palm	None	B/E	Alive 4 yeras

TABLE IV

Author	*Number of Patients*	*Percentage—5-Year Survival*
Batts	25	40
Tracey	6	33
Total Patients—31	Overall Survival—38.7%	

who have a limited survival (three years seven months) without recurrence. In Tracey's series only three patients of the six were considered in the percentage of five-year survival.

As in the diagnosis of an osteosarcoma, a biopsy specimen is the method by which an ultimate differentiation is made in a fibrosarcoma.

The treatment is amputation. Fibrosarcomas are resistant to radiation therapy.

In our series there were four patients with synovial cell sarcomas (Table V). The average age at diagnosis was 17 years; duration of symptoms was seven months. One patient had regional metastasis, and three had no clinical evidence of metastatic disease. Two of the patients died within one year; two are alive two and five years postsurgery without local recurrence or metastasis (50 per cent with a combined survival time of 3.5 years).

No primary tumor was located in the joint cavity. Only about 10 per cent of synovial cell sarcomas originate from the synovial tissue of a joint. Enzinger reviewed 75 patients; the survival rate was from 26 to 50 per cent depending upon the tumor classification (Table VI).

A synovial cell sarcoma is an uncommon tumor. The duration of symptoms may be up to three years. The patient notices a mass that becomes painful. The involved area may appear to be warmer than the surrounding tissue. A history of trauma is not considered a factor as far as the clinical signs and symptoms are concerned.

X-ray appearance is that of a soft tissue mass. Bony erosion is rare. Areas of radiopacity are present. Radiographically, the diagnosis is a suspicion and can only be verified by biopsy specimen.

Microscopic appearance is that of spindle-shaped cells. The cells may be elongated and plump. The slide is characterized by clefts and spaces. The cells lining the spaces are usually cuboidal. In reducing the metastatic rate, early surgery is essential, amputation. Radiotherapy does not offer any increase in prognosis.

TABLE VI

Histological Type	*Number of Patients*	*Survival Rates* 2 YEARS %	5 YEARS %
Pseudoglandular	26	77	50
Fibrosarcoma	22	86	59
Endothelioid	27	34	26

Two patients with primary chondrosarcoma were seen. The average age at time of diagnosis was 37. The symptom duration was five months. In one patient, no surgery was possible as pulmonary metastasis was present. Death was within seven months.

The second patient had a primary segmental 8th rib lesion. He is three and a half years postoperative without clinical evidence of local recurrence or metastasis.

TABLE V

SYNOVIAL SARCOMA

Age	*Race*	*Sex*	*Duration of Symptoms*	*Location of Primary*	*Metastasis*	*Treatment*	*Results*
30	W	F	4 months	Popliteus Muscle	None	Radical en bloc excision	5-year survival
18	N	F	12 months	Left forearm	Regional	Forequarter amputation	Expired 1 year
12	W	M	10 months	Dorsal surface hand	None	B/E amputation	Alive 2 years with out recurrence or metastasis
9	N	M	3 months	Bursa over symphysis pubis	None	Radical excision and radiation	Expired 6 months

A primary chondrosarcoma is difficult to classify precisely. Fibrous and bony components are all too often present when multiple sections are done. Myxomatous tissue may be apparent. Upon physical examination there may be a mass with subsequent pain. Limitation of joint motion may be present. A pathological fracture is rare. Cortical involvement is not present in the early stages. New bone, when it does form, is sparse.

Histologically, the identification of malignancy requires experience. Much of the tissue shows a benign pattern. There are fields in which the cartilage is cellular. The cell nuclei are plump and bilobed.

Only 15 to 20 per cent of primary chondrosarcomas have a five-year cure. A cure results only when an amputation is done as with osteosarcoma. X-ray therapy is only palliative for symptoms in an accessible region or metastasis.

Two patients with rhabdomyosarcoma were reviewed. In one patient, the primary site was the brachialis muscle. Axillary node metastasis was present. A forequarter amputation was advised. At the present time, he has survived five and a half years without evidence of clinical metastasis or local recurrence.

The second patient had rhabdomyosarcoma in the deltoid muscle. There were no axillary nodes involved. A forequarter amputation was done, and he is two and one-half years post-surgery without local recurrence or metastasis.

In 34,476 patients reviewed at the Anderson Hospital in Houston, Texas, 20.6 per cent were classified as rhabdomyosarcomas. The tumors were further broken down into their histological features as embryonal, alveolar, or pleomorphic. Only a liposarcoma is seen more frequently. The embryonal type is the most malignant.

Radiotherapy was not effective in the pleomorphic type. Radiotherapy has been effective when combined with surgical care, in the embryonic tumor. Treatment of choice for any type of rhabdomyosarcoma is radical excision in the form of ablation.

One each case of Ewing's, malignant giant cell tumor, lymphosarcoma and myxoliposarcoma was seen. The 11-year-old who presented chest metastasis from a primary iliac crest lesion with a Ewing's sarcoma died two months after diagnosis.

The patient with a malignant giant cell tumor of the distal femur has five and one-half years survival following a hip disarticulation. The two patients with lipo- and myxoliposarcoma died one to three months after diagnosis. Both had pulmonary metastasis.

The high mortality in primary bone tumors has not been altered in the past 10 years. Pre- and/or postoperative antimetabolites, irradiation, hypothermia, hyperoxygenation, and radioactive materials have not improved the patient's survivability. In a review of 552 malignant tumors, McKenna, *et al.* noted that irradiation for 47 patients with osteogenic sarcomas did not result in a single cure. The combination of preoperative irradiation and surgical ablation was less effective than surgery alone. When local resection was done, the survival rate was less than with ablation.

What laboratory data is necessary? Early diagnosis and the selection of surgery (often radical) is the best treatment offered as of today. The diagnosis of a malignant bone tumor can only be made by a tissue specimen. However, its history, physical findings, exact location, extent in local tissues, vascularity, metastasis, bone formation potentials can and should be assessed.

A. Diagnostic Procedures

1. Arteriograms

The general size of a tumor mass can be outlined with an arteriogram (Figures 1 and 2). No specific tissue diagnosis is possible or should



Figure 1. Arteriogram showing increased vascular pattern concentrated about an osteosarcoma of the distal femur.



Figure 2. Normal arteriogram. A benign bone tumor is present at the fibular head.

be implied. Certain characteristics point toward a malignant mass. These are:

a. increased vascular-arborization
b. rapid arterial filling
c. delayed venous emptying
d. pooling of the contrast dye

The procedure is done under local anesthesia. The incidence of complications (allergy, thrombosis) is less than 2 per cent. Its value can only be assessed as an ancillary guide, not diagnostic. The merit of its use as a primary diagnostic tool remains doubtful.

2. X-rays

Conventional x-rays, anteroposterior and lateral views, show a variety of changes from osteolytic to osteoblastic in malignant tumors (Figure 3). Seventy to 80 per cent of primary bony tumors arise in some portion of the metaphysis. The primary round cell sarcomas as Ewing's, reticulum cell and the myelomas occur in the shaft or in intramembranous bone. A malignant chondroblastoma is invariably present in the open epiphysis. A malignant giant cell tumor is located in a closed epiphysis.

The formation of bony spicules that are aberrant (45 to 90 degrees) to bone occurs dominantly in osteosarcomas or chondrosarcomas. Tumors, as malignant chondroblastoma, are usually small in size. Conversely, chondrosarcomas and fibrosarcomas may achieve large size without metastasis.

Such tumors as Ewing's, reticulum cell, myeloma and giant cell do not usually form bone. Calcification is seen in the osteosarcoma, chondrosarcoma, chondroblastomas and parosteal sarcomas.

Special procedures as planograms, barium enema, G. I. series, barium swallow, pyelograms, cystograms are invaluable tools in searching for primary or secondary sites. A normal study, a barium swallow or pyelogram, should not be interpreted as valueless. Obviously, there are certain circumstances in which the primary tumor of



Figure 3. An osteosarcoma with periosteal elevation, amorphous new bone formation, and cortical erosion.

bone cannot be differentiated from a secondary metastasis. Furthermore, a tissue specimen from the metastatic site may not always be diagnostic of the primary.

3. Isotopes

Radioactive iodine, calcium, strontium, gold, and flouride-18 will concentrate in any vascular mass (Figure 4). Tissue specifics are not possible. A photo- or dot scan of the mass can be made.

A total body scan, in the hands of a well-trained



Figure 4. Isotope concentration (left) at tumor site, outlining the mass seen in Figure 3. The right side is normal.

radiologist, detects an isotope concentration that is away from the primary site, i.e., bony or pulmonary metastasis. Unfortunately, with obvious vascular structures in the pulmonary region, a metastatic lesion lying in proximity cannot be detected.

Then, why do it? Is it just an academic exercise? The isotope exchange outlines the mass, adds to the amassed information as to tumor location. There can be no doubt, however, that its usefulness is limited.

4. Biopsy

Should an aspiration, incisional or excisional biopsy be done?

Lesions that are not accessible by surgical intervention, as areas of the lumbar spine, will necessitate a needle biopsy to determine the type of tumor. When the needle biopsy is negative, this is not conclusive. A positive biopsy may also be limited. The amount of tissue obtained is small; a diagnosis of malignancy may not be possible. This is especially true in cartilaginous tumors or in a benign tumor such as myositis ossificans which may be misdiagnosed as an osteosarcoma.

5. Frozen section

The reluctance of the physician to rely on a frozen section for a diagnosis leading to immediate treatment of a malignancy continues to prevail. In 75 per cent or more of all frozen sections, bone and soft tissue tumors can be specifically classified accurately. The obvious value of a frozen section is to establish the immediate diagnosis of malignancy. Once done, definitive steps are taken for ultimate surgery. There are those low grade sarcomas or bone lesions in which a diagnosis cannot be made on a frozen section. Thus, special stains and permanent sections after decalcification are done.

Too often, a surgeon states, "Let us wait for the permanent sections for I can remember 'so and so' removed a leg for myositis ossificans that was misdiagnosed as an osteosarcoma on a frozen section." The authors do not state that all malignant bone tumors can be diagnosed by a frozen section. Certainly it is prudent to delay extensive surgery when the tissue diagnosis is in doubt. However, to wait for permanent sections when the diagnosis is obvious only adds to the patients' mortality.

6. Alkaline phosphatase

Elevation of the alkaline phosphatase in malignant bone tumors is proportional to the amount of new bone formation or osteoid production at the lesion site or metastatic area. After total tumor removal, the alkaline phosphatase returns to normal limits. There is no correlation between the high elevations prior to surgery, the rate of descent after surgery, and survival.

The obvious values of an elevated alkaline phosphatase after a postoperative normalcy, indicates a metastatic lesion, local recurrence or liver disease. Normal values have been recorded when metastasis has resulted. The merit of an alkaline phosphatase as a barometer of survival is doubtful.

SUMMARY

Only limited conclusions can be drawn in the 33 patients evaluated over the past 10 years.

There is no doubt that arteriograms, scanograms, and alkaline phosphatase studies add to the composite picture. The physician must be aware of their limitations in establishing a diagnosis.

Representative tissue diagnosis (frozen section), and surgery that removes the lesion provide the best results. ★★★

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UNUSUAL AND CUSTOMARY

The patient, having been told that he was in need of complex surgical care, sought out the best surgeon in the community. The procedure was highly successful, and when the patient received the bill, he went to the physician and said that he could not pay it.

"Why didn't you tell me that?" asked the busy surgeon. "I will be glad to reduce the fee by half."

"I can't pay that either, doctor," was the reply.

"All right, in that case, you have my services for nothing," said the exasperated doctor. "If you knew my usual fee and didn't tell me about your situation, why did you come to me in the first place?"

"Doctor," was the straightforward reply, "where my health is concerned, money is no object."

Selection of Patients and Operations For the Ischemic Lower Extremity

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Although there are still some incompletely understood problems in the management of peripheral arterial occlusive disease, many diagnostic and surgical procedures have become standardized to some extent in the last 15 years. The author lists 12 questions that often arise in the practice of vascular surgery. He presents answers on the basis of personal experience and the experience of others as related personally and in the literature.

DIAGNOSIS AND SURGICAL procedures for the relief of peripheral arterial occlusive disease have evolved rapidly and to some extent have become standardized during the past 15 years. While many problems are still incompletely understood, there is increasing agreement in many formerly controversial areas. The following 12 questions often arise in the practice of vascular surgery. The answers are presented on the basis of personal experience related to the experience of others as reported personally and in the literature. Pertinent references are appended for further information for the interested reader.

1. What is the usual site of arterial occlusion in the legs? The actual genesis of arteriosclerotic lesions and the relation of the several etiologic factors considered important is not completely understood. The term "arteriosclerosis" includes several varieties of degenerative disease of the arteries which require brief definition.

In particular, medial arteriosclerosis (characterized by fibrosis, areas of necrosis, calcification, and occasionally bone formation in the media of the artery) should be contrasted with atherosclerosis of the intima (in which there are lipid deposits beneath the endothelium) which tends to enlarge and frequently goes on to arterial thrombosis either because of extensive narrowing of the lumen or because of ulceration of one of the atherosclerotic plaques.

Medial arteriosclerosis in certain cases may result in arterial occlusion but ordinarily does not cause such per se (although it may coexist with intimal atherosclerosis). Thus, in small arterial occlusion, there is ordinarily the initial lesion of atherosclerosis resulting in constriction of the lumen which is later followed by thrombosis as the secondary or final stage of arterial occlusion.

The most common site of occurrence of atherosclerotic narrowing is not precisely that of the most common site of final thrombosis. Thus, it is common for atherosclerotic deposits to occur in the femoral artery in its proximal "common" portion, but the most usual site for initial complete thrombosis is at the hiatus in the adductor magnus muscle known as Hunter's canal. (Certain experimental evidence points toward the actual cause of atherosclerotic plaque formation at certain sites —such as the posterior aspect of the aorta and in Hunter's canal—as due to anatomic fixation at these points.[1, 2])

While arteriosclerosis is "generalized" in the sense that it is widespread, it is "segmental" in the sense that there are localized lesions with areas of lesser involvement at many points. This feature allows arterial reconstruction between regions of patency in the arterial system.

2. What factors effect distal tissue perfusion with blood? The flow of blood through arteries is considerably different from the flow of water through a metal pipe because of the elasticity and vasomotor changes of the blood vessel as well as the to-and-fro flow of the blood.

Although the flow of blood within vessels is a complicated matter,[3] Burton's studies[4] indicate

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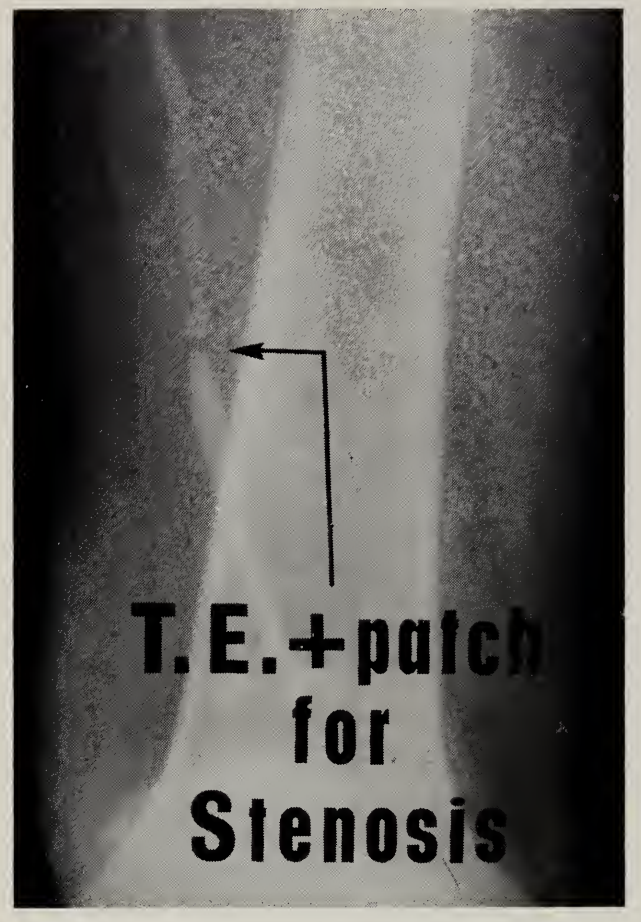


Figure 1. Tight stenosis without occlusion of femoral artery produced disabling calf claudication. Thromboendarterectomy and patch repair relieved symptoms.

that at normal blood pressure Poiseuille's law governs the flow volume approximately.

$$\text{Blood flow} = \frac{(\text{pressure gradient}) \quad (\pi) \quad (\text{radius}^4)}{(8) \quad (\text{coefficient of viscosity}) \quad (\text{length})}$$

Inspection of the equation at once reveals the overriding importance of the radius, since this factor applies as the fourth power. Changes of luminal radius therefore outweigh quantitatively similar variations of the other factors. Figure 1 illustrates stenosis without complete occlusion which was incapacitating a 42-year-old man by claudication. Thromboendarterectomy and lateral patch graft relieved the radial diminution. Symptoms were relieved.

The perfusion of the distal tissues with oxygenated blood is of considerable more importance than is the actual blood flow past any particular arterial point. Main vessel flow may be amplified by collateral circulation past the same point or reduced by arteriovenous shunting distally. Many clinical examples of complete arterial occlusion with excellent collateral circulation providing good perfusion are seen.

The concept of critical closing pressure of small blood vessels is of importance. The widespread belief that even a small blood pressure within an artery means some perfusion of the tissues is incorrect, since the arterioles' inherent muscular tone causes their complete closing at internal pressures which are considerably above zero.[4] This not only explains why tissue perfusion may be completely absent although some degree of arterial blood pressure remains but also furnishes a good explanation of the nature of "vascular spasm," namely, that the critical closing pressure of the vessel is higher than the available blood pressure.

3. What are the important parts of the physical examination? It is recognized that the entire physical examination is of importance, but certain por-

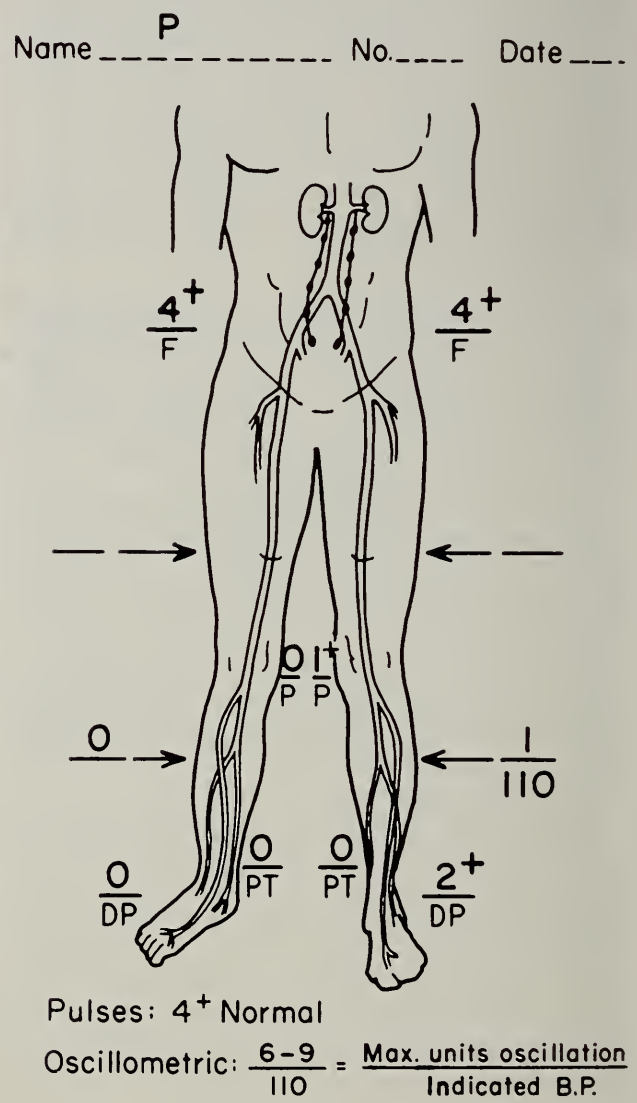


Figure 2. Pulse and oscillometric diagram showing examination of patient whose arteriogram and repair is seen in figures.



Figure 3. Elevation with exercise test.

tions of it bear more directly upon the diagnosis and point toward the proper therapy.

Pulses are examined with the patient lying prone because it is difficult to obtain these properly when the patient is sitting. Pulses are graded from zero to four plus because this encourages careful observation of the actual pulse volume of the individual and allows a fairly good estimate of changes from one examination to another. Oscillometric examination using the Collens instrument is conducted in conjunction with the pulse examination. Figure 2 shows typical findings in the patient whose arteriogram is shown in Figure 6.

The appearance of the foot and toes is observed after a three-minute period of elevation of the feet while the patient lies prone and exercises the feet by dorsiflexion and plantar flexion. This simple clinical examination is not generally described but is quite critical in the detection of occlusion of the arteries (Figure 3).

Arterial changes distant from the suspected point should be carefully sought since abdominal aortic aneurysms, carotid stenoses and occlusions, renal vascular lesions and mesenteric ones commonly coexist with extremity lesions. Recognition of a carotid lesion or of an aortic aneurysm may lead to a decision to repair such prior to extremity revascularization.

4. What is the natural history of atherosclerotic arterial blocks managed without vascular repair? The best long-term study appears to be that of Humphries, deWolfe, Young and LeFevre of 1,850 limbs followed for a period of years without surgical intervention.[5] Less than 3 per cent spontaneously improved due to the development of collateral circulation. Most either continued with claudication or had progressive increase of claudication leading to incapacitation. An appreciable number developed some acute worsening due to further thrombosis which led to severe rest pain, amputation or death. They reported that sudden worsening occurred in 30 per cent with disease primarily located in the femoro-popliteal segments, 27 per cent with disease in the iliac as well as the femoro-popliteal segment and in 11 per cent of patients with the disease limited to the aorto-iliac system.

They concluded first, that the frequency of development of sudden worsening becomes greater as the occlusive site becomes more distal. Secondly, serious worsening usually occurs as a sudden event and spontaneous recovery from such an episode is quite uncommon. There were no early criteria to permit prediction as to which limb would suddenly deteriorate. Further study of their statistical summary and conclusions is recommended to the interested reader, particularly in regard to the favorable effect of surgical reconstruction upon a lowered amputation rate and death rate.

5. What is the role of angiography? While the history and physical examination ordinarily allow a good estimate of the site and extent of the occlusive process in the peripheral arterial system, angiograms furnish the road map to successful definitive management and are invariably necessary for proper treatment. The basic decision for or against surgical repair depends upon the clinical syndrome, but delineation of the site and extent of the obstruction as well as the peripheral reconstitution of the "run-off" vessels constitutes the factor having the greatest secondary effect upon the therapeutic decision. Omission of definitive angiograms for the sake of time and convenience often leads to incorrect therapy or to destructive amputation where salvage is possible.

While some surgeons have attempted to combine angiography with the actual operative procedure, this should be avoided wherever possible to allow diagnostic information to be gathered before an operative decision is made. The angiogram must be interpreted in the light of the clinical background and of the method by which it was

BALTIMORE

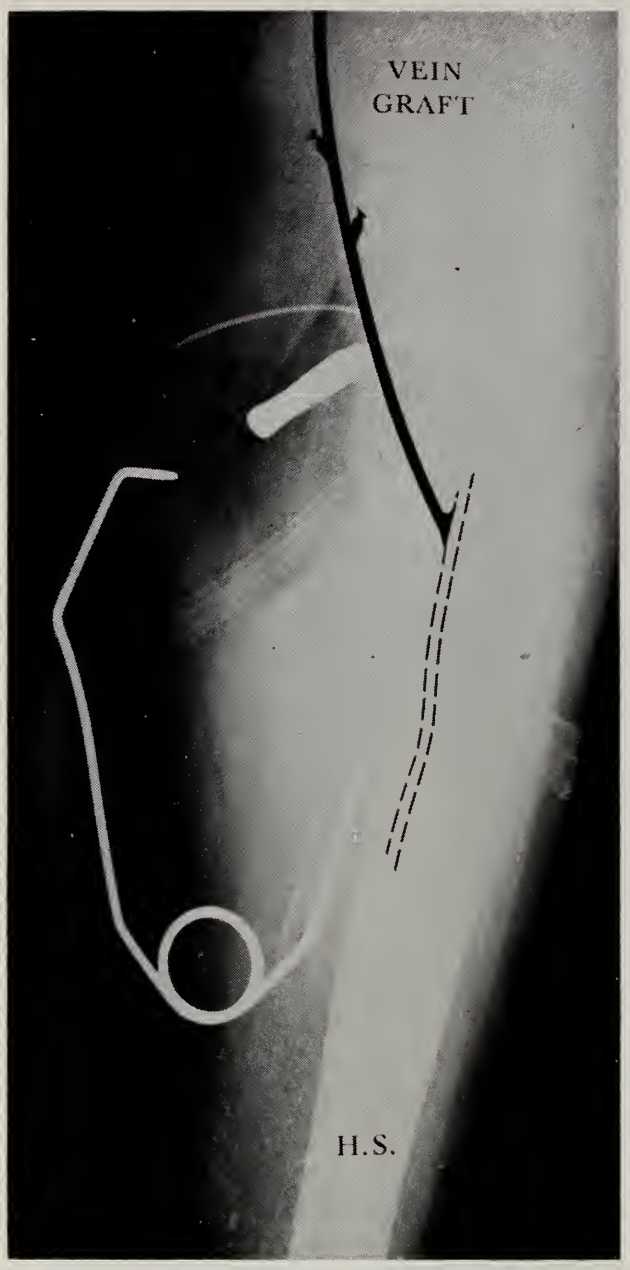


Figure 4. Femoral arteriogram did not show a patent vessel in the calf. Such was found at exploration and the leg saved by grafting procedure.

performed. It is therefore of considerable importance for the surgeon to provide personal correlation and interpretation and not be dependent upon a report from an otherwise unfamiliar observer, Thus, in Figure 4 is shown a femoral arteriogram which appeared to indicate no distal run-off circulation available for a graft. It was believed, however, that the x-ray exposure was too early so the calf was explored and a reversed autogenous vein graft was successfully performed, allowing salvage of a leg with a large ischemic ulcer already present.

TABLE 1

TYPE OF ARTERIOGRAM

Femoral percutaneous needle arteriogram	74
Femoral catheter aortogram	1
Translumbar aortogram	15
Operative femoral or popliteal arteriogram	5
Intravenous aortogram	1
No angiogram made	4
Total	100

While at one time it was believed that one of several available methods of angiography would prove superior to others, it now has become apparent that several methods are useful under various circumstances and that the angiographic technique should be fitted to the individual patient. In Table 1 are summarized the angiographic techniques used for a series of 100 consecutive patients facing early leg amputation. This indicates the preference for percutaneous needle puncture femoral arteriography when the femoral artery is easily palpable.

If the femoral artery cannot be easily palpated, a needle is placed via the translumbar approach and that method is used. Catheter angiography is avoided as much as possible because it is needlessly dangerous to place a catheter within an already atherosclerotic or partially thrombosed vessel. This policy has allowed angiography without loss of life or limb due to the procedure itself during the past decade. Based on this experience, we use angiography freely where indicated but regard it as a potentially hazardous procedure as is any other surgical technique. Angiographic preferences are summarized in Table 2.

TABLE 2

ANGIOGRAPHIC PREFERENCES

Ipsilateral Femoral Pulse		*Contralateral Femoral Pulse*		*Preferred Angiogram*
good	+	good	→	percutaneous femoral arteriogram
poor or absent	+	good	→	1) translumbar aortogram, or 2) retrojection from contralateral femoral
poor or absent	+	poor or absent	→	translumbar aortogram

6. When should surgical repair be done? Arteriosclerosis is a wide-spread disease which occurs to some extent in essentially all elderly people. It must at once, therefore, be recognized that a major surgical procedure is indicated chiefly by

TABLE 3

INDICATIONS AND TIMING OF OPERATION

1. Arterial occlusion without incapacity: nonoperative therapy	
2. Limitation of work or play Constant pain Threatened or minor gangrene	early operation
3. Acute ischemia Progressive gangrene	immediate operation

the clinical situation and not by x-ray findings of angiography alone.[6]

Patients fall into three general categories of clinical symptoms (Table 3). First are those who face early extremity loss from ischemia and who require immediate operation if this is possible. These patients have either continuous pain at rest which is often accentuated at night or they have areas of frank ischemic gangrene or discolored areas of pregangrene.

A second group of individuals are not facing early amputation but have become incapacitated by virtue of severe claudication in the calf, thighs, or buttocks. They should have angiography and early elective repair if feasible. The final group of patients are those whose claudication is minor and incapacitating. It is not believed that they should be subjected to a delicate major operation if they are working or leisure activities have not been seriously diminished by symptoms.

Some patients who would otherwise be candidates for immediate surgical repair have contraindications by virtue of some other lesion such as advanced malignant tumor or severe coronary insufficiency which might be accentuated by an arterial repair which would allow the patient more activity.

A few patients have severe peripheral arterial occlusion so that only one small vessel is left below the knee for blood flow to the foot and toes. If this patient has only claudication but not pregangrene or rest pain, if may be wise to postpone operation for fear that failure might result in immediate amputation.

7. What are the best operations for arterial repair? The proper procedure has considerable bearing on the indications for surgery, since failure to utilize certain repairs or choice of an improper one undoubtedly leads to poor results. Proper selection depends upon availability of all known repairs, which, of course, reflects previous experience with all types of reconstruction. Dedication to a single type repair to the exclusion of others tends to lead to results less favorable than are possible.

The increasing reluctance to implant foreign bodies such as Teflon and dacron prostheses is associated with wider acceptance of autogenous tissue repairs which include autogenous venous bypass and thromboendarterectomy. Not only do experienced vascular surgeons such as Linton[8] report better long-term results with autogenous venous grafts, but the originator of the Edwards crimped graft has now stated that "no synthetic material is likely to be found which will compare with the autogenous tissues, and I for one feel the future of all the replacement will consist of finding better ways to use autogenous material and not in finding an ideal synthetic."[9] Thus, the trend from synthetic tubes to autogenous tissue repair continues.

Table 4 summarizes personal procedures of choice and indicates that synthetic tubes are not used distal to the inguinal ligament if any other type repair is possible. The extensive discussion regarding these indications has recently been well summarized in the symposium entitled "Fundamentals of Vascular Grafting"[10] and will not be repeated in detail here. Sufficient to the argument favoring autogenous tissues for vascular repair is the summarizing statement that such are available for most patients and that if successfully carried out they will remain patent for long periods of time without risk of superimposed infection or other complicating factors common to the synthetic prostheses.

Short occlusions of both the aorto-iliac system and femoro-popliteal system should be cleared by thromboendarterectomy. Bilateral iliac thromboendarterectomies are readily performed but require more time than simple bypass graft, and some patients benefit from the more rapid procedure of bypassing with an onlay synthetic Y

TABLE 4

CURRENT PROCEDURES OF CHOICE

	Short Block	*Long Block*	*Aneurysm*
Large artery (aorta, iliac)	Thromboendarterectomy	1. Thromboendarterectomy 2. Dacron graft	Dacron graft
Small artery	1. Thromboendarterectomy 2. Autogenous vein graft	1. Autogenous vein graft 2. Thromboendarterectomy	Autogenous vein graft

graft placed between the aorta and the iliac or femoral arteries. This is particularly true for long iliac occlusions and less so for short ones.

Longer femoro-popliteal blocks require more lengthy dissection and leave an extensive raw surface which lends itself more readily to postoperative thrombosis. A bypassing graft is usually a better choice of procedure for a long occlusion. Similarly, when the distal end of the repair must lie below the knee joint where the vessels are smaller, there is greater possibility of continued patency following placement of an autogenous vein bypass with a large anastomotic stoma than when thromboendarterectomy is done.

8. What are the results of surgical repair of diseased arteries? The variable results reported reflect not only different techniques and methods but, also, different types of follow-up. Personal statistics are based upon personal re-examination because telephone or letter reports are fallacious and misleading. The most difficult repairs occur in legs facing imminent amputation by virtue of continuous pain, pregangrene or actual gangrene (and these are summarized in another section where it is indicated that 73 per cent of our attempts at vascular repair have been successful).

From this minimal base of success there is an increase if claudication alone is the indication for operation. Analysis of 129 autogenous vein graft bypasses of the femoro-popliteal system shows a 67 per cent overall patency rate. Early failures were due to technical errors as well as to errors in case selection (in attempting to relieve almost hopeless lesions).[11] If these be excluded by considering only the 90 patients whose grafts are known to have remained open three months or longer, the patency rate is 83 per cent.

9. What are the results of surgical treatment in "salvage" cases when leg amputation is imminent? When arterial occlusion has progressed to the point of constant pain at rest or when tissue necrosis threatens or has already occurred, it becomes clear that amputation will be necessary in a short period unless distal tissue perfusion can be increased. Centuries of experience teach that only an occasional extremity is salvaged by nonsurgical methods once the stage of rest pain or of imminent or early gangrene is reached. On the other hand are the considerably better results of an aggressive approach to salvage of such extremities by insisting upon angiography prior to amputation in almost every instance and by a serious attempt to revascularize the extremity in most instances.

Recent analysis has been made of a consecutive series of extremities which were facing early loss by amputation.[12] After discarding cases having only claudication or having noncontinuous pain, there were 114 consecutive legs whose outcome is known. The gross overall salvage rate was 64 per cent. The results in legs having continuous pain only were a little better (69 per cent) than in those where some form of tissue necrosis or gangrene had already occurred (60 per cent) (Figure 5).

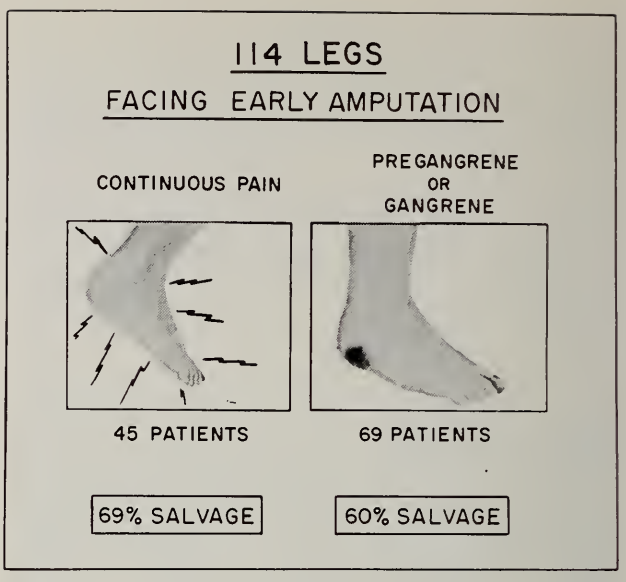


Figure 5. Results of salvage cases (excluding patients with claudication alone).

The general approach to these extremities was to search vigorously for a means of salvage rather than to perform immediate amputation. Most (94 per cent) of the extremities were studied by angiography to determine the feasibility of revascularization. Following complete clinical evaluation it was clear that 10 could not possibly be saved and immediate amputation was performed. Another three had arterial exploration with amputation done immediately when it became apparent that the artery could not be repaired. Eighteen had lumbar sympathectomy with 72 per cent leg salvage. In general these consisted of patients with leg vessels unsuitable for repair either because of disease limitation to the distal arterial tree or because of complete lack of distal run-off. These salvage results indicate the efficacy of lumbar sympathectomy when applied to cases selected with extreme care. Previous experience has indicated to us that if sympathectomy is widely applied to every patient, the results will be poor, however.

The remaining 81 of the total of 114 legs were revascularized by direct arterial repair consisting of thromboendarterectomy, vascular graft or some combination of these. Seventy-three per cent of



Figure 6. This 83-year-old patient's great toe already had black dry gangrene. The only patent distal vessel was the anterior tibial artery. A long bypass of reversed autogenous saphenous vein was placed from common femoral artery to this with revascularization which saved the leg. The toe was amputated.

the repairs were successful in terms of salvage of the leg with ability of the patient to walk usefully post-operatively. Figure 6 illustrates the patent femoro-popliteal vein graft in one such successful instance in an 83-year-old man whose great toe was already gangrenous.

10. What is the risk of surgical treatment of the ischemic extremity? Among the 114 extremities facing early amputation described above there was a total of 11 deaths for a patient mortality rate of 10 per cent. One of these deaths was due primarily to the arterial repair when a synthetic prosthesis became infected and after a series of complications finally led to the patient's death six months later. All the other deaths occurred of causes not directly related to the vascular procedure. Most of these were myocardial infarctions or acute cerebral vascular accidents which are prone to occur in this group of patients whether or not they undergo surgical procedures.

An interesting comparison can be made between the 10 per cent mortality for these revascularization procedures and the 10 per cent mortality occurring in amputations which were studied in four hospitals in this city several years ago.[13] It appears that the risk of death is approximately the same whether the leg is treated by amputation or by vascular repair. These statistics do point toward the serious situation existing in any patient whose arteries have degenerated to the point where major amputation is threatened.

11. What is the role of sympathectomy? Since introduction of lumbar sympathectomy to the United States in the 1920's, there have been recurrent shifts in its popularity between considerable overemphasis to under-utilization. This uncertainty stems from inability to predict reliably the effect of sympathectomy or to determine with certainty its results. Personal experience with repeated evaluation of sympathectomized patients before and after operation over a period of three years, led to abandonment of skin temperature studies and of plethysmography as preoperative determinants and led to reliance upon clinical judgment based upon the history, examination, and angiography study.

Lumbar sympathectomy appears to be considerably more effective in the relief of small areas of pregangrene or actual gangrene than it is in treatment of established rest pain or of claudication. This probably occurs because sympathectomy redirects blood to the skin rather than to muscle tissue primarily.

While some surgeons have advocated preliminary sympathectomy or concomitant sympathectomy, it appears that vascular repair offers a more direct method of increasing tissue perfusion than does sympathectomy, and that it should be offered primarily if the arteries can be reconstructed.

Sympathectomy is reserved for individuals whose arteries are not reconstructible because of distal disease or where the entire problem is too distal for arterial repair. Occasionally the patient still has such high vasomotor tone following arterial repair that a secondary sympathectomy is indicated. Also, to be sympathectomized are those individuals undergoing aortic and iliac surgery where the ganglia are readily available without particular risk or additional important time involved.

12. When should immediate amputation be carried out without recourse to angiography or attempt at arterial repair? (1) Gas gangrene or other ascending severe infection may not permit the time necessary for revascularization; amputation may be required as a lifesaving procedure. Immediate amputation should be done to extremities whose distal tissues have been damaged to

the place where salvage of enough foot to allow walking is impossible.

(2) The socioeconomic situation may indicate immediate amputation at a high level as the best and quickest solution when arterial repair appears quite unlikely of success and where multiple procedures might become necessary.

(3) The patient may not accept chance of failure of vascular repair with later possible amputation and strongly prefers a single and final procedure.

CONCLUSION

Analysis of experience in peripheral arterial reconstruction for arteriosclerotic disease indicates continuation of an aggressive plan of management aimed at rehabilitation of patients incapacitated by claudication and salvage of limbs threatened imminently with amputation. ★★★

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VOICE OF THE NONCANDIDATE

The quadrennial demurrer now being heard from prominent public figures: "I am not a candidate for President and neither is my running mate."

Cine-Angiography and Its Relation to Diagnosis and Treatment of Coronary Artery Disease

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TECHNIQUES OF OPACIFICATION of the heart and great blood vessels with radiopaque contrast material for radiographic study were modified in 1959 by Sones[1] to obtain better visualization of the coronary arteries.

This method of study provides extensive information about the internal anatomy of the coronary arteries, but it is important to remember that little is learned about the functional state of the myocardial circulation which is the important consideration in the evaluation of the symptoms and subsequent management.

A number of studies indicate that most patients with the typical angina syndrome do have anatomic change in the coronary arteries which can be demonstrated angiographically. Most frequently, this involves two or more of the major branches of the coronary arteries. Other patients, however, have typical symptoms and electrocardiographic changes of myocardial ischemia, but normal coronary arteries as demonstrated by angiogram.[2] Some of these patients may have disease of the microcirculation or in the metabolic utilization of oxygen at the cellular level. These findings illustrate the lack of absolute correlation between angiographic anatomy and functional change.

It should be apparent that there is no good method by which the myocardial oxygen deficiency can be determined. Although it has been shown that there is a lack of uniform correlation between the post-exercise electrocardiogram and the presence of coronary artery disease, it continues to be the best method of evaluating the cellular response of the heart to oxygen lack. Patients are encountered with abnormal post-exercise electrocardiograms, chest pain, and normal coronary arteriograms. Some of these patients undoubtedly have either microcirculation obstruction or unusual oxygen-hemoglobin affinity which prevents release of oxygen to the cells.[3] On the contrary, patients with significant narrowing of the lumen of the coronary arteries and, indeed, some who have had previous infarction may have normal post-exercise electrocardiograms. This must imply that there is adequate flow through collateral vessels to the viable myocardium in at least some of these patients.

Coronary arteriography provides detailed information concerning the internal anatomy of the major coronary arterial branches. The authors discuss the use of this procedure in the diagnosis and treatment of coronary artery disease. They observe that it is particularly useful in the evaluation of the atypical anginal syndrome and of the patient considered a candidate for surgical revascularization of the myocardium.

Studies of total coronary blood flow in patients with coronary disease do not correlate with the degree of coronary artery disease when measured at rest.[4, 5] Distinct differences might be found, however, if the total coronary flow were measured during exercise or if the coronary flow through selected regions of the myocardium were measured. It is also of interest that myocardial arteriovenous differences of oxygen, glucose, lactate, pyruvate, and free fatty acids determined at rest are the same in patients with coronary arterial disease and those with normal vessels.[6] It is pos-

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sible that these values might be different under exercise conditions.

From the above considerations, it can be seen that coronary arteriography defines the presence and extent of atherosclerotic disease of the coronary arteries but does not, however, evaluate the functional status of the microcirculation nor the possibility of cellular oxygen deficiency of metabolic origin. Fortunately, the majority of patients with the anginal syndrome have evident atherosclerotic disease which can be demonstrated angiographically.

Of a series of 100 patients with clinical ischemic heart disease evaluated by Eliot and Gorlin,[7] 18 had chest pain and normal coronary arteriograms. Nine of these 18 had classical angina, while the other nine had atypical chest pain. The angiographic demonstration of normal coronary arteries is therefore strong evidence that the heart is not the source of pain in patients with anginal-like pain. Hiatus hernia, gallbladder disease, cervical neuritis, pericarditis, myositis, and various forms of cardiomyopathy may all be responsible for anginal-like pain in this group of patients.

It is for this reason that a method of determining the sufficiency of the coronary blood flow and its effect on the myocardial cell is needed. The patient with anatomic coronary disease may have a hiatus hernia, cervical neuritis, or gallbladder disease, as well as the individual without coronary disease. The demonstration of coronary atherosclerosis does not prove that the heart is the source of the pain. In fact, extensive coronary disease may be found perchance in an asymptomatic patient.

A normal resting and post-exercise electrocardiogram in the patient with anatomic coronary disease should stimulate investigation of other possible causes of chest pain. In the series of 100 patients studied by Eliot and Gorlin, 90 per cent had abnormal electrocardiograms at rest or following exercise. The 10 per cent with normal electrocardiograms had coronary arteriograms which were not qualitatively or quantitatively different from those with abnormal electrocardiograms. This difference might be related to collateral blood supply.

Since absolute knowledge of the anatomy of the coronary arteries will not change the clinical approach to most patients with chest pain, some general criteria should guide the selection of patients for study. The majority of patients with coronary artery disease are probably best treated by a program of graduated exercise, vasodilator drugs, and treatment of hypertension, if present. The use of anticoagulants and anti-lipid pharmacologic agents may be helpful in some instances, although proof of their value is still lacking. When a patient is incapacitated by his pain and forced to take large amounts of nitroglycerin, or when he develops increasing frequency of pain, especially night pain which might suggest impending infarction, additional study is indicated with the idea that surgical treatment might be appropriate.

As pointed out by Sones, perhaps the most valuable information derived from angiographic study is the demonstration of normal coronary arteries in the patient suspected to have angina pectoris. The patient with atypical findings of coronary artery disease may be proved to have normal coronary arteries.

A reasonable selection of patients for study will thus require the best judgment of the clinician and should result in information on which to base treatment. Thus, patients whose disease is incapacitating and for whom surgical treatment is contemplated, and patients incapacitated by doubt as to whether or not they have coronary artery disease should be studied. As a practical course, the patient with findings typical of coronary disease might best be treated conservatively with observation of the course of the disease and evaluated by coronary arteriograms at a later time, if necessary. On the other hand, the patient with severe symptoms or the patient with atypical findings should be studied at an earlier time so that specific recommendations might be made.

The comparative findings in a number of situations are presented in Table I. These combinations of findings emphasize the importance of the post-exercise electrocardiogram in the evaluation of this group of patients. Pain, suggestive of coronary disease, in the absence of angiographic or electrocardiographic changes suggest that the heart is not the source of the pain. Angiographic changes of coronary disease may be found in patients without pain or electrocardiographic abnormality when they are studied for other types of heart disease. Finding normal coronary arteries in the patient with typical pain and "ischemic" change in the post-exercise electrocardiogram suggests a defect in the coronary microcirculation or a metabolic defect in oxygen transport to the cells. The post-exercise electrocardiogram appears to be a useful tool, not only for patient selection for angiographic study, but also to evaluate collateral circulation development. With development of adequate collateral circulation, the post-exercise electrocardiogram may be normal and the pain may disappear.

As with any diagnostic procedure, the danger associated with its use must be balanced against

TABLE I

INDICATIONS FOR CORONARY ANGIOGRAPHY

A. To confirm presence or absence of disease
 1. when symptoms and findings are paradoxic
 2. when there is evidence of unusual disease of coronaries
 3. when there is atypical pain and questionable ECG change
B. When surgical treatment is contemplated
 1. after failure of medical program
 2. in the case of precocious coronary disease.

CLASSIFICATION OF "CORONARY ARTERY DISEASE" BASED ON COMBINATIONS OF ANGIOGRAPHIC FINDINGS, PAIN, AND ELECTROCARDIOGRAPHIC FINDINGS IN PATIENTS WTH "ANGINA"

Coronary Arteriogram	*Pain*	*Post-Exercise ECG*
+	+	+ Coronary disease
+	–	– Early disease Adequate collaterals
+	+	– Adequate collaterals
N	+	+ Microcirculation or O_2 dissociation disease
N	+	– Non-cardiac "angina"

the value of the information gained. There are two potentially fatal hazards associated with coronary arteriography: (1) Precipitation of acute myocardial infarction and (2) ventricular fibrillation. The latter complication is readily reversible, but a threat to life, nonetheless.

Fatal complications should occur in less than 0.5 per cent of the patients studied, an amazingly low incidence when it is remembered that patients with a severe and an unpredictable disease are being studied. Occlusion of the brachial artery and, rarely, the subclavian artery may require surgical treatment but do not usually result in significant morbidity. Reactions to contrast media are rare and are usually of the urticarial type. Although these complications are rare, they must be given consideration before angiographic study is recommended.

The selection of patients for myocardial revascularization is difficult. There has not yet been sufficient control data to evaluate the benefit of this surgical treatment. The volume of blood flow through the implanted vessel may be inadequate to improve myocardial oxygenation. Further, neither the effect on life span nor the degree of protection afforded against infarction has been shown. There is always the possibility of development of arterial disease in the implanted vessel. If a metabolic defect is responsible for the disease to begin with, should the implanted vessel and its collaterals be immune?

These unanswered questions emphasize that this is still an experimental procedure which should be used with some reservation. It is my opinion that at the present time, surgical treatment should be reserved for those patients severely limited by their disease, who have failed to improve following medical management. After a patient is selected for surgical treatment, coronary arteriograms are helpful in planning the approach since the regions of the myocardium with deficient blood flow can be identified and surgical devascularization can be directed to those areas. Knowledge of the myocardium in these areas is also important, since revascularization of diffuse scar and thinned myocardial wall is impossible.

SUMMARY

"Coronary artery disease" may exist as three syndromes: (1) atherosclerosis of the major arteries, (2) obliterative disease of the microcirculation, and (3) failure of oxygen release at the cellular level.

Coronary arteriography provides detailed information concerning the internal anatomy of the major coronary arterial branches. Coronary arteriograms are particularly useful in the evaluation of the atypical anginal syndrome and the evaluation of the patient considered a candidate for surgical revascularization of the myocardium.

The functional response of the myocardium to obliterative arterial disease is difficult to measure. The post-exercise electrocardiogram is the best clinically available method to evaluate the physiologic response of the myocardium to arterial obstructive disease. ★★★

6601 S. Main (77025)

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Radiologic Seminar LXXIII: Benign Leiomyoma of the Stomach

KENNETH O. WILLIAMS, M.D.
Jackson, Misssissippi

LEIOMYOMA IS the most common of the smooth muscle tumors of the stomach and was first described by Morgagni in 1762. The neoplasm arises from the muscular coats of the stomach or from the muscularis mucosa and occurs most commonly in the region of the pars media and the antrum of the stomach. Usually these tumors are single and small; however, they may be multiple. Occasionally they may reach a very large size. Sarcomatous change is common, and variation in the size and shape of the cells is not proof of malignant change. The presence of a large number of mitotic figures strongly indicates the possibility of malignancy.

Symptoms may be those of a peptic ulcer or may be vague abdominal discomfort. In time, a central ulceration usually occurs and penetrates deeply into the tumor. This may produce bouts of massive bleeding or continuous oozing of blood from the ulcer crater. Occasionally, chronic anemia may be the presenting symptom.

Sponsored by the Mississippi Radiological Society.



Figure 1. Plain film reveals a mass outlined by air in the gastric fundus.



Figure 2 reveals the same lesion in the barium-filled stomach. The leiomyoma is outlined by arrows, and a central arrow points to an ulcerating area.

The radiographic appearance is that of a mass in the stomach which is somewhat smooth in outline. A characteristic finding is a fleck of barium near its center which represents an ulcer crater. Occasionally a mass-like density may be visualized in the gastric air bubble on the plain abdominal film. ★★★

5834 Sleepy Hollow Road (39211)

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The President Speaking

'To Each and All'

TEMPLE AINSWORTH, M.D.

Jackson, Mississippi

THE CURRENT ASSOCIATION year comes to a close at our 100th Annual Session, and all things being equal, I shall become the 20th living past president of your association within a couple of weeks. Instead of this, my final page in your JOURNAL as president of the Mississippi State Medical Association, I would much prefer to be dispatching 1,400 personal letters to my colleagues throughout our state. But since this is not possible, I shall ask a special indulgence to address this page in a personal manner.

Since May 18, 1967, it has been my privilege to represent you in the forums of the American Medical Association, in our nation's capital, in the regional conference, in the small committee, and in a host of state meetings. But best of all, it has been my privilege to visit many of your component medical societies and to meet you in your home communities. You have received me and Mrs. Ainsworth with traditional Mississippi hospitality, flattering attentions, and warm cordiality. We can only be grateful for your gestures as we are for your friendship.

The compensations of being president of our association are largely intangible, but they are priceless, as my predecessors will testify. Perhaps the greatest satisfactions have been in renewing old friendships and in making new ones. In the language of the teenagers, you've just got to be there to appreciate the vitality, excellence, and enthusiasm of the young physician. The new medical generation is splendidly trained, keenly interested, and scientifically deep. And as old friends enter the ranks of our seniors, their maturity of judgment, breadth of perspective, and richness of experience permitted me to find new wisdom and wider horizons of understanding.

No, I can't write you individually, but I can tell you personally at Jackson. And the trip to your 100th Annual Session need not be made for this alone, because it is an occasion you will not want to miss. Let me thank you there. ★★★

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EDITORIALS

Responsibilities of the Physician in Workmen's Compensation Cases

GEORGE H. MARTIN, M.D.
Vicksburg, Mississippi

I

As Mississippi becomes more industrialized, most physicians in the state at some time find themselves involved not only with "on the job" sick or injured patients, but also with the valid interest of an employer, a Workmen's Compensation Commission, and usually an insurance company. If the disability arises out of the course of employment, the Workmen's Compensation Laws apply, and the cost of medical care becomes the responsibility of the employer or his insurance carrier.

Although most disabilities are the results of physical trauma on the job, there are also many conditions which arise from contact with toxic substances, causing irritation to the skin, the lungs, or to the eyes, ears, or nose. Thus, all specialties become involved, more frequently the surgeon, the general practitioner, and orthopedic specialists, but other consultants are often needed including the dermatologist, ophthalmologist, radiologist, cardiologist, and even the psychiatrist. Thus, there is scarcely any physician who should not, in sheer self-defense, familiarize himself with the demands that are peculiar to Workmen's Compensation cases.

As in all instances, the physician's first responsibility is to deliver to his patient the best possible care within his power to render. But the Workmen's Compensation Law also calls for procedures which are necessary to support legal requirements providing for the replacement of the lost income, the cost of medical care, and rehabilitation.

II

One of the prime prerequisites is the prompt reporting by the physician of the diagnosis and expected prognosis of occupational injury or illness to the patient's employer and insurance company. The employer needs to be notified so that he can make arrangements to have the patient's work covered by some other employee, often requiring a change, or overtime, in shift work. Sometime it may be necessary to employ a new person to fill the patient's place. The insurance company needs to be informed of the preliminary diagnosis, with an estimate of the length of total and partial disability, so that the proper compensation may be started as soon as possible.

As soon as the patient has recovered from the

From the Department of Surgery, Mercy Hospital-Street Memorial.
Surgery member, Committee on Occupational Health, Mississippi State Medical Association.

acute injury, but is left with some permanent or partial disability, it is the physician's responsibility to see that rehabilitation is vigorously pursued so that the patient may return to his original job or, if necessary, to a different job for which he can be trained during his convalescence.

Disability determinations are the responsibility of the Workmen's Compensation Commission. However, it is the physician's responsibility to describe the extent of impairment of physical functions as it affects the patient's ability to work. The American Medical Association has performed a service of great value to the medical profession by producing its series of Guides to Measurement of Physical Impairment. Thus, total or temporary partial disabilities can be reported in percentage of loss as compared to the whole body.

It is often necessary that the physician testify before a hearing of the Workmen's Compensation Commission, for he is frequently the only witness who can fairly advise the board as to the true relationship of the worker's complaint to his job. This does not signify that the physician should take sides in what may be a bitter legal controversy—he should calmly testify impartially as to what, in good conscience, he believes are the true facts. However, his obligation to appear and give fair testimony is as much a part of his job as the emergency care of an injured employee.

III

Finally, all physicians should champion a cause for the employment or re-employment of the handicapped. It has been shown over and over again that handicapped people when placed in positions for which they are qualified, make efficient, loyal, dependable employees. It is understandable that management is reluctant to hire the disabled patient under fear that second injuries, or exaggeration of existing injuries, may cause legal entanglement. Nevertheless, experience repeatedly shows that hiring the handicapped is good business. It pays off in the long run from the manager's standpoint, and the urgent need from the standpoint of the injured is obvious. Physicians should encourage management to hire the handicapped as a matter of good employment practice.

With the change in the employment climate in Mississippi, it becomes the responsibility of any physician handling Workmen's Compensation cases to make himself knowledgeable of the laws and responsibilities as related to on-job injuries. The injured worker naturally looks to his physician not only for the best possible medical care but also expects his continued interest in seeing that he receives the best opportunity for maximum recovery. In these endeavors, we should not fail.

★★★

The Street Clinic (39180)

BHG's Poll: Voice of the Consumer?

As with quotations from the Holy Bible or even the works of Shakespeare, a poll is available to prove just about anything nowadays. No physician need be reminded that there are almost polls of medical polls, and as opinion research goes, the physician is just about the most polled, questioned, and queried individual in society.

Comes now *Better Homes and Gardens,* an attractive, well-edited, and usually an absorbing magazine which, more often than not, generates quite a zeal to redecorate the old homestead and fix up the yard. But BHG is also getting into the polling business, and it's going medical, at that. Publishing a 109-item questionnaire in its October and November 1967 issues, BHG has just announced its findings, claiming that they are "the voice of the American consumer for the next decade."

While the survey covered the full spectrum of consumer interests, much emphasis was placed by the magazine on the medical aspects. Actually, the survey was generally concerned with property taxes, college expenses, the credit dilemma, family finances and attendant woes, homes, government and business operations, and food costs.

The wrath of BHG's respondents, according to the magazine's releases, was apparently reserved for drug manufacturers, drug wholesalers, and pharmacists. About six out of 10 said that the price of prescription drugs is much too high, but of these respondents, 69 per cent were over 55 years of age. About a fifth of the younger respondents recognized that drug prices were not out of line with the high costs of development after research.

The drug manufacturers got the blackest eye, with 42 per cent of the respondents saying that they were responsible for the high prices. Next in line for castigation were pharmacists with 31 per cent saying that the local drug store is the

reason for high costs. Only 21 per cent thought that the drug wholesaler was the reason.

More than half of those replying to the survey said that they favored use of nonprescription, over-the-counter preparations for such ailments as insomnia and indigestion. A fourth of the respondents, however, recognized this practice as dangerous self-diagnosis.

Only a third of the sample said that compared with other professional individuals, physicians' fees were too high. The remaining two-thirds feel that physicians' fees are high but justified by training and are quite fair.

Medicare must not be quite the panacea that the Johnson administration hails it to be, since a whopping 80 per cent said that they were unwilling to finance it for those under age 65 through additional Social Security taxes. In fact, 18 per cent were for abolishing Medicare hands down, and a miniscule 13 per cent wanted it for everybody.

The sample consisted of about 280,000 replies, and the data were processed and interpreted by the Opinion Research Corp. of Princeton, N.J. This tends to accord credibility to the study. If the voice of the consumer is to be tested, let those sponsoring the tests use honest yardsticks with the professionals who are qualified to read them.—R.B.K.

HEW's Handwriting on Tomorrow's Walls

An obscure speech in an unpublicized meeting at Washington recently puts a lot of handwriting on the wall and clearly merits the careful attention of every professional person, every state and local official, and for that matter, every citizen as a taxpayer. In an address entitled "Public Services Under a Government of Laws," Alanson W. Willcox, general counsel for the Department of Health, Education, and Welfare, said some astonishing things. That he said them in an HEW forum, held in the HEW auditorium, in the HEW building, to an HEW audience explains why his message will be news.

Mr. Willcox is a liberal attorney by today's criteria. He begins his exposition on the logical and perfectly correct premise that ours is a government of laws, the antithesis of a despotism, and that the Constitution of the United States brooks no despots. We can all agree—regardless of our respective impressions of the current applicability of his assertion—that this was true in 1776 and for a while thereafter.

He continues by pointing out that when there was a contest between a citizen and the state, the laws required the state to bend over backwards because of the citizen's inherent inability to measure up to the state in legal strength. With this as his springboard, Mr. Willcox takes off in an amazingly unorthodox dive which almost misses the water.

He says that "we ought now to amend our creed to say that we live *in part* under the rule of law. For, conceived in so narrow a fashion, a government of laws fails to touch the things that government does *for* people, in contrast to what it does *against* them. It fails to touch public benefits, public services, or for that matter, public employment. We need a broader concept if this article of our faith is to be meaningful in the world of today."

Mr. Willcox deplores the fact that a government of laws is made up of constitutional guarantees that "are couched in the negative." He wants welfare, employment, all sorts of public benefits to be assured in case and constitutional law. If he is to be understood at what appears to be face value, then he will settle for nothing less than everything for everybody. And the Congress can relegate itself to the necessary but obviously unimportant task of just putting up the money.

The HEW counsel is heartily in favor of a judicare program, legal services for everybody, and he twits the idea that the poor can secure justice—that's for the rich and economically able. His peroration is that "equality, in short, is unequally available."

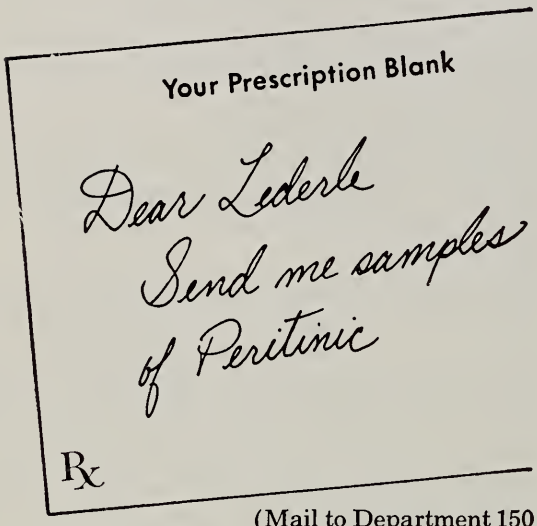
From this point, he makes example after example of HEW's gigantic spectrum of public programs and how it needs a basis of "right" for administering them. If this is the handwriting of tomorrow's HEW on the walls of today's forums, then there isn't any time to lose in getting a good deal more of that old time, 1776-variety constitutional guarantee that is well-couched in the negative.—R.B.K.

Aw, Rats!

The subject of rats, be it the necessity of a special bill in Congress for their extermination or the heyday the rodents were supposed to have enjoyed during the New York garbage collectors strike, is often in the news. For some reason, it

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* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic?)

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Vitamin B_1	7.5 mg
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Vitamin B_{12}	50 mcgm
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Niacinamide	30 mg
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was reported time and again in the press that there are eight million rats in New York City. A recent government study (safely made after the extermination appropriation was emotionally put on the law books) says that a more rational estimate is one million, give or take a few thousand.

Actually, a study by the U. S. Public Health Service made in 1963 put the New York rat population at only half a million. The Health Insurance Institute, not usually identified with all of this rat business, did some researching and came up with still another study which put the rat population of London at "one rat per person." This, believes HII, is the basis for the popular, and inaccurate, eight million rats in New York.

Now, the U. S. Department of the Interior, also in the rat business, says it thinks New York has about 1.5 million rats. In any event, we may know something about the extent of this health menace for sure: New York City has taken some of the federal money and hired a rat expert. It is his job to decide if it is possible at all to count the city's rat population with any degree of accuracy.

It is with temerity and reluctance that we suggest that the Fun City set a few rattraps.—R.B.K.

LETTERS

SIRS:

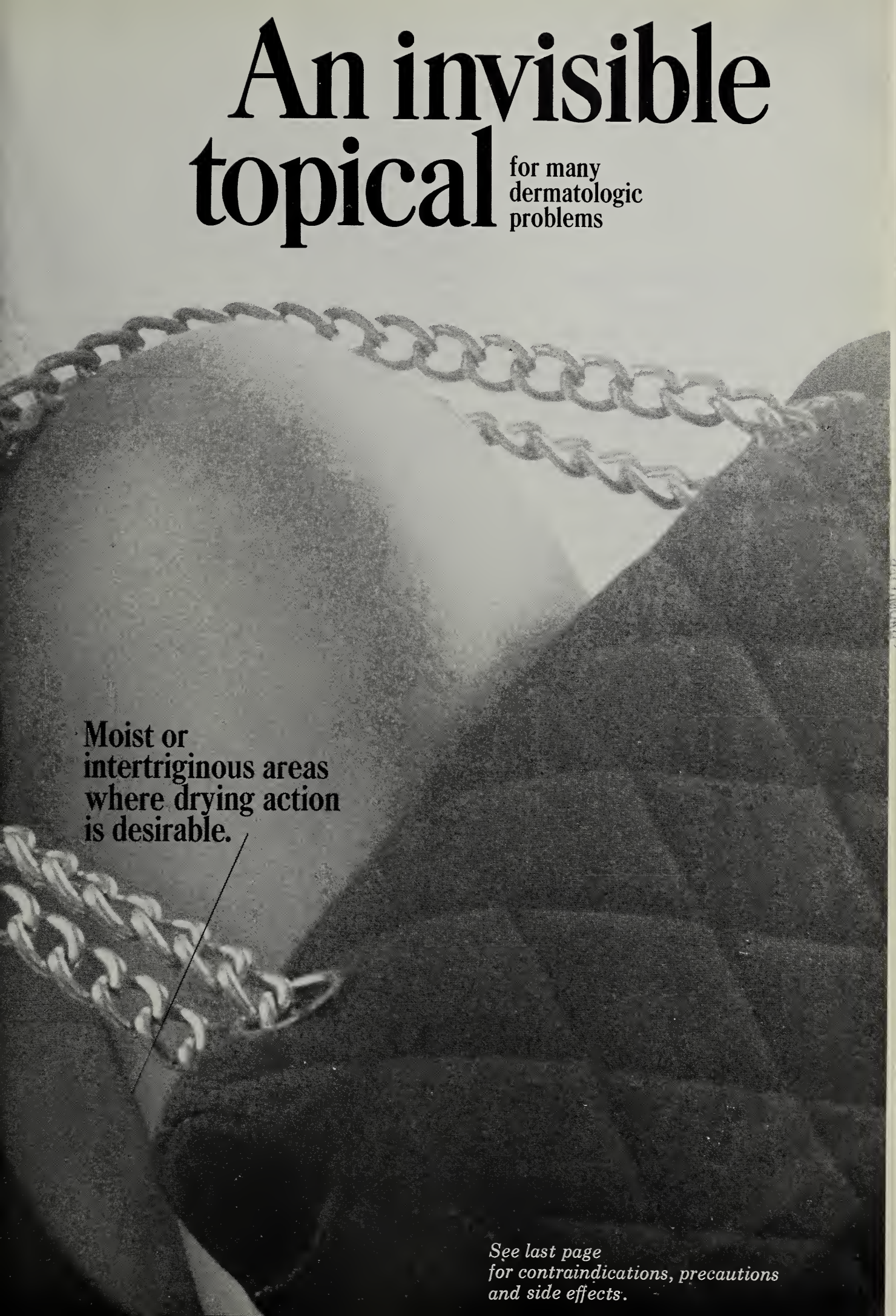
I have just returned from an operation and I regret that I did not get your copy of the MISSISSIPPI STATE MEDICAL ASSOCIATION JOURNAL until today. I am delighted that you sent me this journal. I am more delighted that the doctors of the state of Mississippi saw fit to print such a wonderful article concerning a Parchman plasmapheresis program. I feel that this program will be one of the greatest financial rehabilitation programs the penitentiary can undertake.

I hope that you will read this letter to your Board of Trustees and tell them that I am humbly grateful for their cooperation, and if they need me for any future work, I will be delighted to meet with them.

CORBET PATRIDGE
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SCHLATER, MISS.

An invisible topical

for many dermatologic problems



See last page for contraindications, precautions and side effects.

Structurally unique topical steroid in propylene glycol vehicle produces rapid response in many dermatoses.

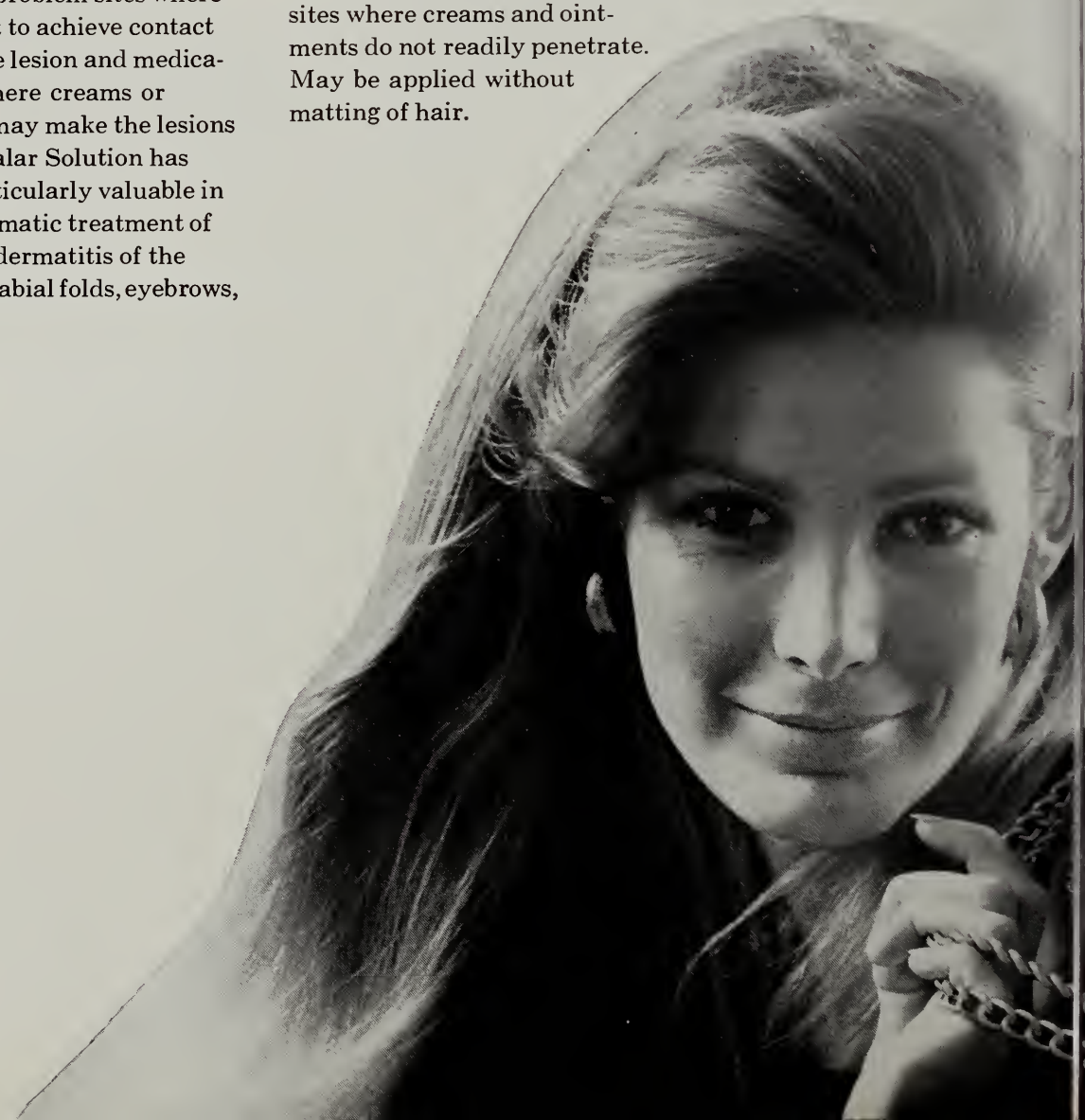
Synalar Solution produces rapid antiinflammatory, antipruritic action through its unique topical corticosteroid, fluocinolone acetonide. The propylene glycol vehicle provides additional benefits for therapy at problem sites where it is difficult to achieve contact between the lesion and medication—or where creams or ointments may make the lesions worse. Synalar Solution has proved particularly valuable in the symptomatic treatment of seborrheic dermatitis of the scalp, nasolabial folds, eyebrows, ears, and in flexural folds such as the axillae, inframammary, umbilical and anocrural areas. It has also been reported to achieve excellent results in the adjunctive management of atopic dermatitis, contact dermatitis, neurodermatitis, nummular eczema, psoriasis, and sweat retention syndromes in these problem sites.

Penetrates the hairy sites.

In many areas of the body, hair gets in the way of treating the underlying dermatitis. The propylene glycol vehicle of Synalar Solution permits penetration and dispersion at sites where creams and ointments do not readily penetrate. May be applied without matting of hair.

Ideal for moist or intertriginous areas.

Propylene glycol is strongly hygroscopic and is especially useful where sweat retention is a problem. Its low surface tension permits easy spreadability in difficult-to-treat body areas. A number of studies have also shown that propylene glycol has inherent antimicrobial activity.



Cosmetically acceptable for exposed areas.

The propylene glycol vehicle of Synalar Solution possesses many useful cosmetic properties. Clear and greaseless, it is not sticky or messy, will not stain clothing or skin. In exposed areas of the body where cosmetic appeal is important, Synalar Solution shows nothing but results.

Economical—a little goes a long way.

Because of the properties of propylene glycol and the milligram potency of fluocinolone acetonide, a small quantity of Synalar Solution goes a long way. Also, the prescription price of a 20 cc. plastic squeeze bottle of Synalar Solution is surprisingly low. Thus, your patients obtain economy with the proved efficacy of a potent, truly advanced topical corticosteroid.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: In some patients with dry lesions, the solution may increase dryness, scaling, or itching. Application to denuded or fissured areas, such as genital or perianal sites, may produce a burning or stinging sensation. If this persists and dermatitis does not improve, discontinue medication. Although propylene glycol has antiseptic activity, there should be careful initial evaluation and follow-up of infected sites. Incomplete response or exacerbation of lesions may be due to true infection, which requires susceptibility testing and appropriate therapy. On the other hand, saprophytic or low grade infections may clear spontaneously under the influence of Synalar Solution alone. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Side Effects: Side effects are not encountered ordinarily with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

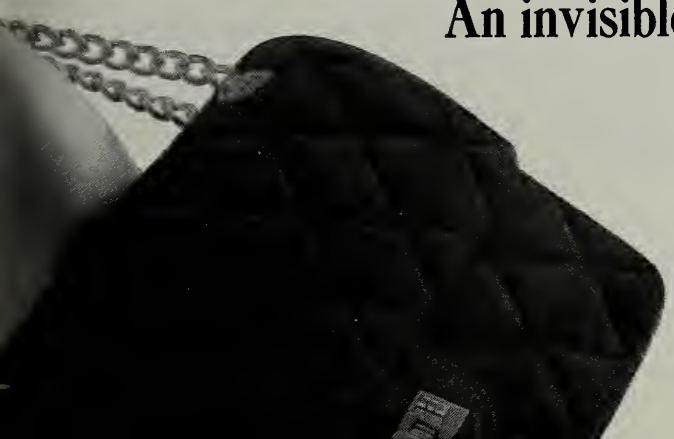
Availability: Synalar (fluocinolone acetonide) Solution 0.01% in a propylene glycol vehicle with citric acid as preservative. 20 and 60 cc. plastic squeeze bottles. *Also available:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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Solution
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MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 16-20, 1968, San Francisco, Calif.; Clinical Convention, Dec. 1-4, 1968, Miami Beach, Fla. F. J. L. Blasingame, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

American Academy of General Practice, Annual Meeting, Sept. 13-20, 1968, Las Vegas, Nev. Mr. Mac F. Cahal, Executive Director, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

Southern Medical Association, Annual Meeting, Nov. 18-21, 1968, New Orleans, La. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 100th Annual Session, May 13-16, 1968, Jackson. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. S. E. Field, Jr., Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. William O. Barnett, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 668, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday Quarterly, Jefferson Davis Memorial Hospital, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Second Wednesday March, June, September, and December. Herbert R. Power, Vaiden Clinic, Vaiden, P.O. Box 85.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday every month. J. M. Howell, 215 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, P.O. Box 1230, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, 1513 Clay Street, Vicksburg, Secretary.

Weariness without cause"



Psychic tension with depressive symptomatology?

"For weeks I've done practically nothing and I'm always tired. I wake up tired and I go to bed tired. It's really absurd."

When the patient complains of fatigue, and you can find no organic cause, you recognize that it may serve her as a means of avoiding responsibilities or facing an emotional problem. It is, in effect, a psychological retreat behind a somatic cover of continuous fatigue —one of the many depressive symptoms often associated with psychic tension.

She needs counsel and reassurance, and perhaps a tranquilizer to attenuate excessive tension and help restore the capacity to cope. As an aid to successful management, consider the value of Valium® (diazepam). As psychic tension is eased by Valium therapy, secondary depressive symptoms too may subside. The patient feels more capable, therefore more hopeful; better able to handle situations of intense stress.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects —particularly with known compounds which may potentiate action of Valium, such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See **Precautions.**) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg, and 10 mg; bottles of 50, 100 and 500.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Valium® (diazepam)

helps relieve psychic tension with associated depressive symptoms

POSTGRADUATE CALENDAR

GENETICS, ORTHOPAEDICS AND CONGENITAL ANOMALIES

University Medical Center
May 13, 1968, beginning at 9 a.m.
Sponsored by the Orthopedic Surgery Division, University Medical Center
Participants:

J. William Hillman, M.D., professor of orthopedic surgery and chairman of the department, Vanderbilt University School of Medicine, Nashville, Tenn.

John F. Jackson, M.D., professor of preventive medicine and associate professor of medicine, University Medical Center

Nell Ryan, M.D., assistant professor of pediatrics and director, Birth Defects Clinic, University Medical Center

Robert R. Smith, M.D., instructor in neurosurgery, University Medical Center

W. Lamar Weems, M.D., assistant professor of surgery, University Medical Center

Monday Morning

Genetics
Dr. Jackson

Congenital Anomaly and the Pediatrician
Dr. Ryan

Genetics and the Orthopaedist
Dr. Hillman

Neurosurgery and Congenital Anomalies
Dr. Smith

Urology and Congenital Anomalies
Dr. Weems

This postgraduate education seminar will be held in conjunction with the regional meeting of the American Academy of Orthopedic Surgery.

CIRCUIT COURSES

East Central Circuit Course
Meridian—May 7, Northwood Country Club, 6:30 p.m.
Session 3—A Practical Approach to Diagnosis and Management of Diarrhea, Dr. Libio Mora
Current Practices in the Diagnosis and Management of Pancreatitis, Dr. Albert Meena

FUTURE CALENDAR

May 13-16
Mississippi State Medical Association

May 13
Genetics, Orthopaedics and Congenital Anomalies

DEATHS

Day, Carl A., Yazoo City. M.D., Emory University School of Medicine, Atlanta, Ga., 1915; postgraduate study, Chicago, one year and New York, New York, 1925-1930; died February 14, 1968, aged 76.

Minor, Lancelot Longstreet, DeSota County. M.D., University of Tennessee College of Medicine, Memphis, 1899; chief intern Vicksburg Charity Hospital, one year; postgraduate training Memphis City Hospital, two years; served as Secretary of DeSoto County Medical Society for 30 years; past member of Board of Trustees, Mississippi State Medical Association; Emeritus member of MSMA and member of the Fifty Year Club; died March 2, 1968, aged 92.

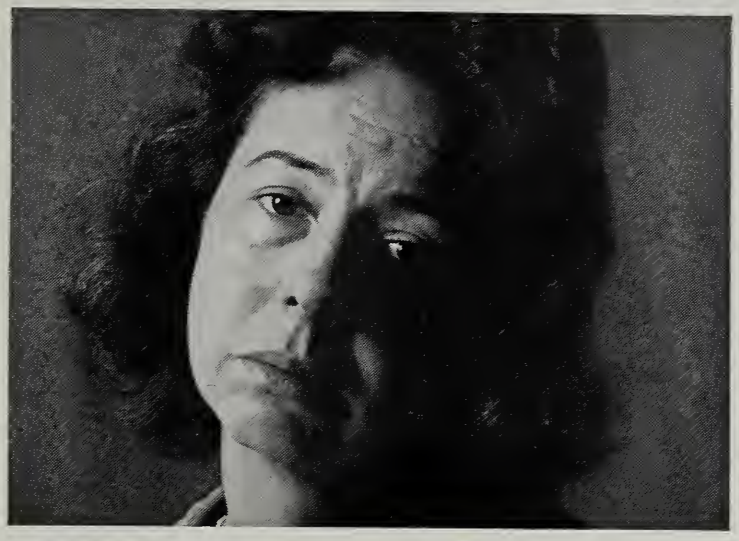
Salter, Cary Weathersby, Macon. M.D., Memphis Hospital Medical College, Memphis, Tenn., 1910; died March 1, 1968, aged 80.

Stevens, Woodson Anderson, Biloxi. M.D., Tulane University School of Medicine, New Orleans, La., 1907; interned Turo Infirmary, two years; past President of Coast Counties Medical Society; Emeritus member of MSMA and member of the Fifty Year Club; died March 14, 1968, aged 86.

Wasson, Perry Reaves, Lyon. M.D., Memphis Hospital Medical College, Memphis, Tenn., 1908; Emeritus member of MSMA and member of the Fifty Year Club; died February 27, 1968, aged 81.

Weeks, William Henry, Yazoo City. M.D., Memphis Hospital Medical College, Memphis, Tenn., 1903; interned Memphis City Hospital, one year; Emeritus member of MSMA and member of the Fifty Year Club; died March 20, 1968, aged 93.

When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription —prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Lederle

327-8

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

Abella-Fernandez, Manuel Esteban, Whitefield. Born Havana, Cuba, April 27, 1927; M.D., School of Medicine, Havana University, Havana, Cuba, 1953; interned Calixto Garcia Universidad Hospital, Havana, one year; residency, Maternidad Obrera Hospital and Clínica de Niños de M. Obrera Mariahao, Havana, Cuba, seven years; member, American Academy of General Practice; elected Jan. 3, 1968, by Central Medical Society.

Adcock, George Alman, Jr., Biloxi. Born Shreveport, La., Nov. 20, 1934; M.D., Louisiana State University School of Medicine, New Orleans, 1960; interned Charity Hospital, New Orleans, one year; general surgery residency, V.A. Hospital, New Orleans, La., one year; otolaryngology residency, Charity Hospital, New Orleans, La., three years; elected Jan. 3, 1968 by Coast Counties Medical Society.

Aden, Barry Burleigh, Jackson. Born Yazoo City, Miss., Aug. 1, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned University Medical Center, one year; general surgery residency and anesthesiology residency University Medical Center, Jackson, one year each; member, Central Anesthesia Society; elected March 5, 1968, by Central Medical Society.

Brent, Alvin Eugene, Jr., Jackson. Born Jackson, Miss., June 6, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned University Medical Center, Jackson, Miss., one year; medical residency, University Medical Center, two years; fellowship, University of Mississippi School of Medicine, one year; elected Nov. 9, 1967, by Central Medical Society.

Brock, Hobson Darney, Jr., Jackson. Born McComb, Miss., July 9, 1937; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned Baptist Memorial Hospital, Memphis, Tenn., one year; pediatrics residency, John Gaston Hospital, Memphis, two years; elected Oct. 3, 1967, by Central Medical Society.

Brown, John Augustus, Jr., Jackson. Born St. Louis, Mo., June 15, 1931; M.D., University of Mississippi School of Medicine, Jackson, 1960; interned St. Thomas Hospital, Nashville, Tenn., one year; radiology residency, Vanderbilt University Hospital, Nashville, Tenn., one year; medical officer, USN, two years; dermatology residency, Jackson Memorial Hospital and University of Miami School of Medicine, Miami, Fla., three years; elected Nov. 7, 1967, by Central Medical Society.

Draughn, Daniel Hawkins, Jackson. Born Hattiesburg, Miss., Aug. 28, 1936; M.D., University of Mississippi School of Medicine, Jackson, 1961; interned Letterman General Hospital, San Francisco, Calif., one year; pediatrics residency, Fitzsimons General Hospital, Denver, Colo., two years; diplomate, American Board of Pediatrics; elected Nov. 7, 1967, by Central Medical Society.

Forshner, John Gordon, Jackson. Born Yazoo City, Miss., May 27, 1936; M.D., Tulane University School of Medicine, New Orleans, La., 1961; interned Southern Pacific General Hospital, San Francisco, Calif., one year; residency, Grady Hospital, Atlanta, Ga., one year; Charity Hospital and Tulane University School of Medicine, two years; elected Nov. 7, 1967, by Central Medical Society.

Godfrey, Wendell Douglas, Jackson. Born Adamsville, Ala., Jan. 29, 1934; M.D., Medical College of Alabama, Birmingham, 1959; interned Carraway Methodist Hospital, Birmingham, Ala., one year; general surgery residency, three years and plastic surgery residency, two years, University Medical Center, Jackson; elected Nov. 7, 1967, by Central Medical Society.

Hilbun, Benton McInnis, Tupelo. Born Lucedale, Miss., Sept. 6, 1936; M.D., University of Mississippi School of Medicine, Jackson, 1961; interned University Hospital, Jackson, Miss., one year; general surgery residency, University Medical Center, Jackson, Miss., four years; thoracic surgery residency, University Medical Center, Jackson, one year; elected Jan. 8, 1968, by Northeast Mississippi Medical Society.

Hogan, Marcus Leon, III, Hattiesburg. Born Hattiesburg, Miss., Sept. 29, 1935. M.D., University of Mississippi School of Medicine, Jackson, 1963; interned Brooke General Hospital, San Antonio, Tex., one year; residency, Baylor Medical School, Houston, Tex., three years; elected Sept. 14, 1967, by South Mississippi Medical Society.

Hopkins, Donald Andrew, Crystal Springs. Born Jackson, Miss., July 12, 1940; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned John Peter Smith Hospital,

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW **PITMAN-MOORE** DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



"Nothing else I've tried seems to work, so I decided to give you a crack at it."

Ft. Worth, Tex., one year; elected Dec. 12, 1967 by South Central Mississippi Medical Society.

LEWIS, HENRY LEANDER, Magnolia. Born Liberty, Miss., Nov. 26, 1937; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned Wilford Hall, USAF Hospital, San Antonio, Tex., one year; elected Dec. 12, 1967, by South Central Mississippi Medical Society.

LONG, JOHN HAMILTON, Hazlehurst. Born Hazlehurst. Miss., March 2, 1937; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned Duval County Medical Center, Jacksonville, Fla., one year; elected Sept. 19, 1967, by South Central Mississippi Medical Society.

LUMMUS, FLOYD LAMAR, Tupelo. Born Weir, Miss., July 21, 1935; M.D., University of Mississippi School of Medicine, 1960; interned St. Thomas Hospital, Nashville, Tenn., one year; residency University Hospital, Jackson, two years; residency Ochsner Foundation Hospital, New Orleans, La., one year; elected January 8, 1968, by Northeast Mississippi Medical Society.

MCDONALD, THOMAS JOSEPH, Mantachie. Born Collins, Miss., Dec. 13, 1935; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned John Sealy Hospital, Galveston, Tex., one year; elected March 12, 1968, by Northeast Mississippi Medical Society.

PERRY, ALTON RHODES, JR., Long Beach. Born Natchez, Miss., April 1, 1936; M.D., Baylor University College of Medicine, Houston, Tex., 1961; interned Confederate Memorial Hospital, Shreveport, La., one year; residency, University of Texas Medical Branch, Galveston, two years; elected Jan. 3, 1968, by Coast Counties Medical Society.

ROBERTSON, BROWN, Tupelo. Born Memphis, Tenn., March 8, 1934; M.D., University of Tennessee College of Medicine, Memphis, 1959; interned Nashville General Hospital, Nashville, Tenn., one year; otolaryngology residency, University of Tennessee College of Medicine, Memphis, four years; elected Jan. 8, 1968, by Northeast Mississippi Medical Society.

SMITH, JOHN LARRY, Hattiesburg. Born Enid, Okla., Oct. 10, 1934; M.D., Tulane University School of Medicine, New Orleans, La., 1960; interned United States Public Health Service Hospital, Norfolk, Virginia, one year; pathology residency, Charity Hospital, New Orleans, La., three years; pathology residency, Ochsner Foundation Hospital, New Orleans, one year; elected Dec. 14, 1967, by South Mississippi Medical Society.

WILLIAMS, CHARLES OTHO, Jackson. Born Forest, Miss., April 30, 1940; M.D., University of Mississippi School of Medicine, Jackson, 1966; interned University Hospital, Jackson, Miss., one year; research fellowship, pathology, University of Mississippi School of Medicine, Jackson, one year; elected Jan. 2, 1968, by Central Medical Society.

YATES, ANDREW JACKSON, III, Jackson. Born Memphis, Tenn., May 2, 1934; M.D., University of Tennessee College of Medicine, Memphis, 1958; interned City of Memphis Hospitals, one year; pediatrics residency, City of Memphis Hospitals, Tenn., two years; elected Oct. 3, 1967, by Central Medical Society.

PERSONALS

JOHN C. ADAMS, JOHN F. LUCAS, SR., E. M. MEEK, S. G. MOUNGER, HOWARD A. NELSON, and FRED M. SANDIFER of Greenwood were honored by the United States Selective Service System in recent ceremonies for uncompensated service. Each was presented certificates and pins as evidence of the recognition.

JOSEPH B. BECKER of Brookhaven has announced the opening of his offices at 203 W. Congress St. where he will limit his practice to urology.

E. E. BRAMLITT of New Albany has been elected president of the Union County Chapter of the American Cancer Society, Mississippi Division. The chapter has as its goal the raising of $2,500 in Union County during the 1968 crusade.

CURTIS W. CAINE, JOHN D. BOWER, and HILARY H. TIMMIS of Jackson appeared as principal essayists in a recent seminar conducted at the Edgewater Gulf Hotel at Edgewater. The scientific program was sponsored by the University Medical Center for the operating room nurses and technicians. The essayists respectively limit their practices and academic endeavors to anesthesiology, cardiac and thoracic surgery, and medicine with emphasis on hemodialysis.

MARY CLARK of Hattiesburg and JIM G. HENDRICK of Jackson have been appointed consultants to evaluate Head Start programs by the American Academy of Pediatrics. They join other Fellows of the Academy in similar work in the National Head Start Medical Consultation Service

When it's time for Thorazine® brand of chlorpromazine



...can you depend on less?

For profound calming effect in moderate to severe mental and emotional disturbances of everyday practice.

Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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Smith Kline & French Laboratories, Philadelphia SK&F

in cooperation with the U. S. Office of Economic Opportunity.

BILLY T. COLLUM of Fulton became the 23rd annual recipient of the Good Citizen Award sponsored by the *Itawamba County Times*. Selection of the honoree is by ballot of citizens of the county.

J. P. CULPEPPER, JR., of Hattiesburg was principal speaker at the recent initiation banquet at the University of Southern Mississippi. He is a past vice president and trustee of the American Medical Association and served for 16 years as Mississippi delegate to AMA.

BENJAMIN P. FOLK, JR., of Jackson served as Mississippi delegate to the Boston annual meeting of the American Society of Internal Medicine. ASIM seeks high standards in professional practice and patient care through activity in the socioeconomic, scientific, and political aspects of internal medicine.

JAMES D. HARDY of Jackson, professor and chairman of the department of surgery at the University Medical Center, was commended by the Mississippi State Senate which adopted a concurrent resolution calling attention to his leadership in the field of heart transplantation.

CHARLES M. HEAD of Jackson has been named chief of staff at St. Dominic-Jackson Memorial Hospital. He succeeds T. K. WILLIAMS who served as chief of staff during 1967-68.

ARCHIE C. HEWES of Gulfport has formally opened the Hewes Square Shopping Center comprising a one block area at Pass Road and Hewes Ave. The development also has 14 members in the Hewes Square Merchants Association.

C. C. HIGHTOWER of Hattiesburg was honored by his local Rotary Club for 50 years service in membership during its own 50th anniversary celebration recently. Dr. Hightower is a 50 Year Club Member of the state medical association as well as an Emeritus Member.

CHARLES A. HOLLINGSHEAD has become associated with A. F. Moss of Ellisville with offices in the municipal hospital.

JOHN F. JACKSON and ARTHUR W. ST. CLAIR of Jackson have been elected Fellows of the American College of Physicians. Named associate members, a preliminary degree in advancement to fellowship, were JOHN I. DAVIS of Natchez and GRAHAM B. SHAW of Jackson.

GUY C. JARRATT of Vicksburg is the new chairman of the Easter Seal speech correction program in his home community. He limits his practice to pediatrics.

JAMES O. MANNING and FRANK A. WOOD of Jackson have been named members of the 1968 Crusade Committee of the Hinds County Unit of the American Cancer Society, Mississippi Division.

MAURA J. MITCHELL of Ellisville has been awarded the Americanism Medal of the Daughters of the American Revolution by the Nahoula Chapter of DAR. Dr. Mitchell, wife of the Jones County Health Department director, SHELBY W. MITCHELL, was the 1965 recipient of the MSMA-Robins Award.

JOHN R. MULLENS, JR., of West Point has resumed his practice at 122 East St.

J. C. PASSMAN of Natchez has announced the removal of his offices to 55 Sergeant S. Prentiss Drive where he limits himself to orthopaedic surgery.

CHARLES PRUITT, JR., of Magee has been appointed 4th Congressional District chairman for the Mississippi Republican Party. He has served as county party chairman since 1956 and is currently a member of the State Republican Executive Committee.

ELBERT A. WHITE, III, of Corinth has become a founding member of the new little theatre group in the northeast community, the Corinth Theater Arts.

DAVID B. WILSON of Jackson has been elected vice president of the Jackson Rotary Club. He is currently serving as president of the American Hospital Association and is director of University Hospital at Jackson.

Robins Markets New Sulfonamide

Sulla® (sulfameter), a long-acting sulfonamide, was introduced nationally on April 1 by A. H. Robins Co., Richmond-based pharmaceutical manufacturing firm.

The 500 mg. pale green, scored tablets are available in bottles of 50 and 500.

Sulla is offered for treatment of acute and chronic urinary tract infections. Detailed information concerning the use and administration of this prescription drug is contained in the informational brochure.

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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PMA Shares Concern Over Care Costs

The pharmaceutical industry shares the same objective as the President in the quest to provide quality medical care at reasonable cost for all of our citizens, C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, said in commenting on the President's special health message to Congress. "Toward that end, our research-based companies this year will reach the half-billion dollar mark in annual research expenditures, seeking new and improved pharmaceutical products," he said.

Escalating health costs are justifiably a matter of national concern, Mr. Stetler noted. Recent figures indicate they rose 6.6 per cent in 1966, and that the rise has been continuing. "The only moderating influence is prescription drug prices, which have declined 10 per cent on the Bureau of Labor Statistics Index in less than ten years," he said.

"Moreover, prescription drugs take only 9.8 cents of the health care dollar—compared to 11.7 cents in 1957. Clearly, the industry's products are succeeding in protecting health and reducing the cost of illness. We believe this is a fine performance at a time when all other prices are surging upward," Mr. Stetler added.

"As to the proposed drug compendium," he said, "the industry thinks it is desirable and appropriate for a bill to be introduced so that the issue can be thoroughly explored by appropriate Congressional committees. The PMA has been meeting frequently with government agencies and with medical and scientific groups to study the need for such a complex and comprehensive work. We have found that the greatest need is to find out what physicians, the actual users, really need and want.

"Consequently, the PMA recently contracted with the Opinion Research Corporation of Princeton, New Jersey, to conduct a national survey to determine the views of the medical profession as to the need for a new compendium and, if so, what it should contain and under whose auspices it should be published. Until we find out, it is idle to assume that a new compendium is needed or what its format should be."

Mr. Stetler said that the industry is in full accord with the President's effort to cut medical costs, if possible, in federal programs. He noted that many firms within the industry, through rebates on welfare prescriptions and through lower prices on large scale purchases by local, state and

federal agencies, have already helped to bring about substantial savings.

"We do have a concern that price alone not be the only consideration in the prescribing, dispensing or purchase of prescription drugs," he said. "Quality, too, must be maintained so that recipients do not become second-class medical citizens. This is a real danger if the myth of the generic equivalency of drugs prevails."

"Let me make clear that the industry is not opposed to drugs marketed by their generic names. Large and small companies alike make and sell products under brand and generic names. But we strongly believe that the manufacturer source should be identified and that the physician should have the freedom to prescribe as he deems best for his patient. Certainly he should take price as well as quality into consideration."

In adopting purchasing practices and policies, the federal government should be aware of the fact that numerous scientific studies, and the records of the Defense Supply Agency, attest to the fable of generic equivalency, Mr. Stetler stated. "Drug products with the same active chemical ingredient are by no means always the same, nor do they produce the same therapeutic results. Thus assurance of a reputable source for quality products must be a part of the purchasing decision," he said.

"It should be emphasized again that there are two drug manufacturing industries in this country —one that is quality conscious and research-oriented with high standards and national distribution of its products, and one with limited capabilities that simply copies—or attempts to copy—the most popular dosage forms of widely prescribed drugs and sells them usually in limited markets," the PMA president said. "If the former is unduly penalized, its research efforts must necessarily shrink. The result could be what nobody wants—the drying up of the sources of new effective agents on which the future of drug therapy depends."

Hill-Burton Grant Will Add to UMC

The University Medical Center has been awarded a $750,000 grant in Hill-Burton funds to extend the University Hospital obstetrical-gynecological beds, construct an 88-bassinet nursery for newborns and add more general beds.

New facilities will add a fourth floor to an addition still under construction on the south side of the complex. State monies were appropriated by the 1966 legislature.

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When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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Dr. Tom Mitchell Serves in South Viet Nam in AMA-USAID Program

Dr. Tom H. Mitchell of Vicksburg is serving in South Viet Nam under the American Medical Association Volunteer Physicians for Viet Nam program. He anticipates that his two months tour will end in sufficient time for him to return to the United States and attend the 100th Annual Session of the Association.

Dr. Mitchell, head of the Department of General Practice at Mercy Hospital-Street Memorial at Vicksburg, is currently chairman of the state medical association's Committee on Nursing and is a former officer of the West Mississippi Medical Society and the Mississippi Academy of General Practice.

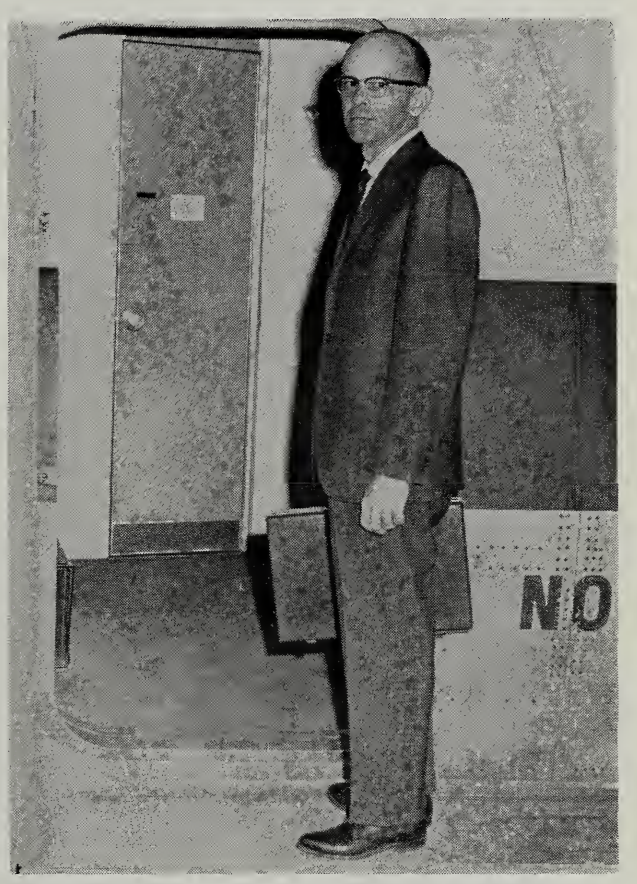
He is a graduate of Mississippi State University, and he received the M.D. degree from the Tulane University School of Medicine after receiving a two year medical certificate from the University of Mississippi School of Medicine at Oxford.

Volunteers under the AMA-USAID program care only for civilians in South Vietnamese hospitals, and none of their duties is militarily-related.

AMA Volunteer Physicians for Viet Nam is administered by the American Medical Association, under contract, for the United States Agency for International Development. It is a program designed to use the volunteer services of U.S. physicians to assist in meeting the health needs of the Vietnamese civilian population.

The program was an outgrowth of a request by the Vietnamese government to the U.S. government to help obtain the volunteer assistance of the U.S. medical profession. Under the impact of 25 years of war, health services in South Viet Nam had become inadequate to maintain the health of the people. Of the 1,200 Vietnamese physicians, for example, nearly 800 are in military service and unavailable for full time civilian practice.

About 50,000 Vietnamese civilians are treated in hospitals annually for war-related injuries. Major diseases of South Viet Nam include tuberculosis, typhoid, cholera, plague, intestinal parasitism, and infectious diarrheas among children. Primarily to the high disease incidence, the life expectancy of the Vietnamese male is said to be 35 years.



Dr. Tom H. Mitchell boards Northwest Orient Flight No. 3 for Tokyo at Chicago en route to his post in South Viet Nam under the AMA-USAID volunteer program.

A continuing need exists for volunteer physicians. Particularly needed are general surgeons, orthopedic surgeons, general practitioners and internists. Other specialists are needed from time to time.

Volunteers are not compensated for their services under the program, receiving only their transportation, housing, and expenses of $10 per day. Each serves a 60 day tour at one of 18 provincial hospitals. While each institution is civilian, teams of military physicians and medical corpsmen are assigned by USAID to provide staff continuity for the volunteer program.

About 24 to 32 American volunteer physicians are needed every 60 days to maintain staff strength, AMA says.

To be accepted as a volunteer, the American physician must be in good health and not more than 55 years of age. No dependents may accompany him, even if the dependent is medically qualified.

Medical Examiners Elect Dr. Helpern

The National Association of Medical Examiners held its first annual meeting in Chicago, where it elected officers, a board of directors and an executive committee and adopted by-laws for the organization.

The association elected as its president Dr. Milton Helpern, Chief Medical Examiner of New York City, and one of the founders of the organization. Dr. Joseph W. Spelman, Medical Examiner of Philadelphia, was elected vice president and Dr. Leslie Lukash, Medical Examiner of Nassau County, East Meadow, New York, was elected secretary-treasurer. All three officers will serve one-year terms.

The meeting adopted the following aims and purposes as part of the by-laws:

To improve and make more effective the official investigation of sudden, suspicious and violent deaths under the medical examiner system; to strengthen the administration and operation of the medical examiner system; to assist in and encourage the establishment of the medical examiner system in areas where such a system is not now in effect; to establish, maintain and promote proper standards for a model medical examiner system; to disseminate accurate information regarding the medical examiner system and its contributions to the administration of justice and the protection of the health of the community; to advance the professional interests of the medical examiners, including those relating to the administrative and career aspects of their work; to conduct studies, sponsor publications and undertake other activities and projects designed to assist medical examiners in improving the quality of their work; and to establish and maintain a code of ethics.

The Association plans to conduct a membership drive to obtain as many qualified members as possible.

Membership in N.A.M.E. is open to all medical examiners, pathologists and other licensed physicians who have responsibilities in connection with the official investigation of sudden, suspicious and violent deaths.

Squibb Offers Film on Hypertension

A new film, "Hypertension: The Challenge of Diagnosis," has been produced by the American Heart Association assisted by a grant from E. R. Squibb & Sons, Inc. The film demonstrates and emphasizes the fact that the proper treatment of hypertension can be determined only when diagnostic measures have found the cause of hypertension and the damage it has done.

Visually, the film follows the case of a typical patient with no significant complaint, whose elevated blood pressure was first noted incidentally, and who had a family history of vascular disorder.

First, possible causative factors are considered. Listed are diseases most often implicated, together with significant signs and symptoms. What damage has been done to the patient is then sought, noting the organs most commonly affected. Significant signs of symptoms of the patient are described. Following are the steps of a thorough physical examination and the reasons for them for evidence to support clues already obtained or to suggest alternatives. Possible laboratory studies are described to substantiate a suspected cause of secondary hypertension.

The film concludes with a brief discussion of treatment, stressing the highly individualized patient management and that nearly every case represents a therapeutic trial which may take many months to complete.

The color, sound, 20-minute, 16 mm. film is available for professional medical audiences from local Heart Association chapters or from E. R. Squibb & Sons, Inc., 745 Fifth Avenue, New York City.

MIC Approves New Jackson Center

Dr. Dorothy Moore has announced approval by the Mississippi Interagency Commission on Mental Illness and Mental Retardation of a proposal for the construction of a Jackson Mental Health Center.

If federal construction funds are approved by the U. S. Public Health Service, the proposed center would be the second for Mississippi since the state launched its Regional Mental Health Program with formation of the M.I.C. July 1, 1966.

The first center was established in Tupelo October 1, 1967. It is the Mental Health Complex of the North Mississippi Medical Center, serving Benton, Chickasaw, Itawamba, Lee, Monroe, Pontotoc and Union counties.

The Jackson Mental Health Center would be operated by St. Dominic-Jackson Memorial Hospital, the applicant, which is seeking federal funds to cover two-thirds of the construction cost.

The hospital's share would be $598,683.33, and the federal share would be $1,197,366.67, for an estimated total cost of $1,796,050 for construction.

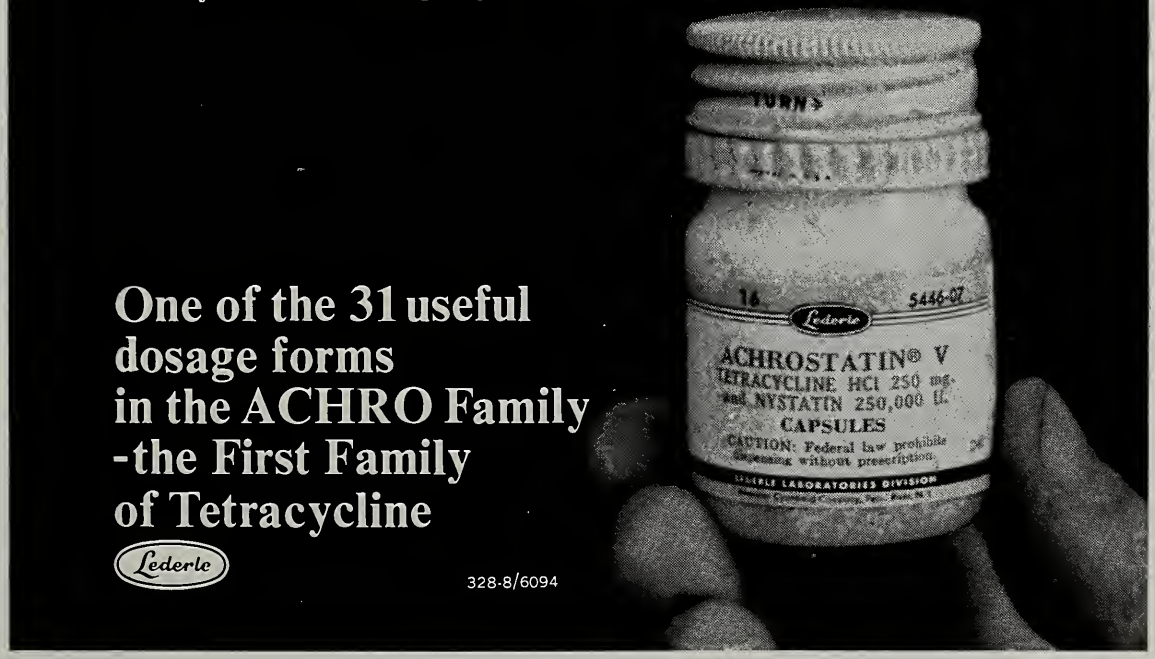
Dr. Moore, who is program director for the M.I.C., said the center would provide the five basic services required of all units under the Community Mental Health Centers Act of 1963, which is administered in Mississippi by the M.I.C.

These include inpatient services, outpatient services, partial hospitalization, 'round-the-clock emergency services, and consultation and education services to community agencies and professional personnel.

A new 56-bed unit in St. Dominic's hospital would provide inpatient and emergency services. The other three services would be provided in a separate facility on the hospital grounds.

The center would serve the first judicial district of Hinds county, containing approximately 180,000 people, of which some 160,000 live inside Jackson and the other 20,000 live in the suburban area.

The M.I.C., in 1966, established 14 multi-county planning regions. The first judicial district of Hinds county is the "Center A" portion of



Region 9, as delineated in the Mississippi Plan for the Construction of Community Mental Health Facilities. The "Center B" portion includes the remainder of Hinds county, plus Claiborne, Copiah, Rankin, Simpson, Smith and Warren counties. The state plan calls for the eventual establishment of another center to serve this area.

The M.I.C., in January of 1967, was formally recognized by the Department of Health, Education and Welfare as the agency to administer construction funds in Mississippi. These federal funds must be matched at the local level, since no state matching funds have been made available.

The M.I.C. consists of five members—the chief executive officers of the five state agencies with programs involved in various phases of work related to mental illness and mental retardation or in the training of personnel in these fields.

The agencies include the State Board of Health, Department of Education, Welfare Department, Board of Mental Institutions, and Board of Trustees of Institutions of Higher Learning, represented, respectively, by Dr. Frank J. Morgan, Jr., Garvin Johnston, Arthur J. Winstead, C. Seth Hudspeth and Dr. E. R. Jobe. Hudspeth is chairman.

State laws passed in 1966 authorize the establishment of regional mental health and mental retardation commissions to plan the regional programs. The commissions are made up of one person appointed by each participating county. The Hinds county board of supervisors appointed Jackson businessman Alvin P. Flannes as commissioner from Hinds county.

Wallace Steps Up Representatives' Training

Wallace Pharmaceuticals, which has recently increased its international force of professional representatives, has instituted a formal program of education to make its carefully selected field men the most effective information experts in the industry.

The latest development in this education program is the establishment of a Masters Course, which is an advanced three-year program to instruct its staff in anatomy and physiology, the physiology of disease, the symptoms of disease, and their treatment.

In creating this unique program, Wallace demonstrated its awareness of the dramatic increase in the number of new drugs introduced in the last decade. This drug explosion has imposed a massive and ever-increasing burden on those concerned with the fight against disease.

UMC Surgeons Win Top SSC Honors

University Medical Center surgeons won top honors for an exhibit shown at the Southeast Surgical Congress in Washington, D. C., March 23-27.

The first place award winning exhibit, "Improving the Results of Strangulation Obstruction," was prepared by Dr. W. O. Barnett, professor of surgery, and surgery residents Dr. Walter Jones and Dr. Mart McMullan.

Dr. Barnett was elected vice president of the organization which represents some 2,000 surgeons.

Dr. Corssen Heads Anesthesiology at UA

Dr. Guenter Corssen has been appointed professor and chairman of the Department of Anesthesiology at the Medical College of Alabama. His appointment, effective April 1, was announced by Dr. S. Richardson Hill, Jr., Medical College dean.

Dr. Corssen is presently professor of anesthesiology at the University of Michigan Medical School, Ann Arbor.

Born in Bremen, Germany, Dr. Corssen received his medical degree from the University of Hamburg Medical School in 1950, and subsequently served an intership and a year of residency in obstetrics and gynecology at the University of Hamburg Hospitals. Then Dr. Corssen came to the United States for a residency in anesthesiology at the University of Texas Medical Branch, Galveston, 1952-54, and later served on its faculty until accepting an appointment at the Michigan Medical Center.

Dr. Corssen, during the past several years, has been investigating the clinical application of a drug which, once injected into a muscle or vein, rapidly produces general anesthesia lasting 10 to 20 minutes. This drug has received attention for its applications in oral surgery, burn care, procedures in otology (the ear), and simple office surgical procedures; it has proved to be highly effective on children.

Simultaneously Dr. Corssen has been exploring "neurolept" analgesia, a new approach to the control of pain during surgical procedures. This technique allows for selective depression of various areas of the central nervous system which are responsible for pain perception and pain conduction. Total depression of the brain and other vital organs of the body is avoided, and no undesirable side effects have been noted. Preliminary findings indicate that Dr. Corssen's method is especially advantageous for older, high-risk patients who must undergo major surgery.

Dr. Hill said the appointment is "highly significant to many programs of education, patient care and research at the Medical Center."

"Dr. Corssen is outstanding in the field of anesthesiology, and we are most fortunate to have him join our faculty in what is certainly a key position. Through his leadership we will expand these programs, particularly in the training of specialists in anesthesiology—an area of medicine which needs many more highly trained individuals," Dr. Hill added.

A Diplomate of the American Board of Anesthesiology, Dr. Corssen holds memberships in the International Anesthesia Research Society, the American Society of Anesthesiologists, the New York Academy of Sciences, the American Medical Association and the American Association of University Professors, plus other specialty and scientific organizations.

In addition to having authored or co-authored over 60 articles published in both American and German professional journals, Dr. Corssen has received several national awards for scientific exhibits before the annual meetings of both the American Medical Association and the American Society of Anesthesiologists. He is also credited with the preparation of eight scientific movies dealing in the fields of anesthesiology, cardiovascular surgery and pharmacology.

Dr. Rodolfo R. Allarde, assistant professor of anesthesiology at the Medical College of Alabama, has been acting departmental chairman.

AMA Offers Health Careers Exhibit

To satisfy a growing demand for a lightweight exhibit appealing to the broad range of medical careers, rather than one emphasizing only physician careers, the AMA has developed a colorful tabletop exhibit, "Health Careers."

Four of these exhibits are now available from the Exhibits Section, Program Services Department, for Careers Day programs in schools, health fairs, state fairs and other programs.

Featuring a color transparency of the cover of the AMA's careers handbook, *Horizons Unlimited,* the full-color folding exhibit, which is eight feet wide and 40 inches tall, calls attention to the fields of specialization and other specialized areas of interest open to Doctors of Medicine and more than 20 principal allied fields ranging from medical librarian to dentistry.

"There's a place in MEDICINE for every qualified student," the exhibit emphasizes.

Since "Health Careers" weighs only 120 pounds, less than half that of the exhibit, "Medicine as a Career," shipping costs correspondingly are reduced. Recipients must pay round-trip shipping costs. Those desiring to order the exhibit should give a minimum of 30 days' notice, although several months is preferable. Loan orders will be filled on a "first come, first served" basis.

Orders for suitable AMA careers literature to be displayed at the exhibit should either accompany exhibit orders or be placed separately with the Program Services Department.

Medicine-Insurance Congress Is Set by AMA

The close link between clinical and life insurance medicine will be explored by a congress on medicine and insurance to be held in San Francisco on June 15.

The meeting, co-sponsored by the Association of Life Insurance Medical Directors of America and the American Medical Association, is the first such meeting of the two organizations.

The congress, which immediately precedes the AMA annual meeting, will be highlighted by a morning panel of insurance company medical directors offering their views of clinical medicine.

Part of the afternoon will be devoted to aspects of disability insurance and rehabilitation.

Dr. Milford O. Rouse, president of the AMA, will speak in the morning on the mutual concerns of the medical profession and insurance companies in the area of clinical and insurance medicine.

Luncheon speaker will be Dr. James P. Cooney, senior vice president for medical affairs of the American Cancer Society.

Featured speaker in the afternoon will be Earl Clark, C.L.U., president and chief executive officer of Occidental Life Insurance Co. of California.

He will discuss the present and future relationships of insurance and medicine.

The morning's panelists will review underwriting problems posed by people with serious ailments. Presentations will be given on heart disease, cancer, diabetes, obesity, tension, strokes and the like. The panelists are:

Dr. Richard S. Gubner, director of the diagnostic services division of the Equitable Life Assurance Society of the United States (New York City); Dr. Harry A. Cochran, Jr., vice president and chief medical director of Lincoln National Life Insurance Co. (Fort Wayne, Ind.); Dr. D. Sergeant Pepper, senior medical director of Connecticut Mutual Life Insurance Co. (Hartford); and Ardian Gill, F.S.A., vice president and actuary of The Mutual Life Insurance Co. of New York.

Dr. Thomas S. Sexton, vice president and chief medical director of Massachusetts Mutual Life Insurance Co. (Springfield), will moderate.

The morning session chairman will be Dr. Whitman M. Reynolds, director of insurance medicine at Equitable Life.

Dr. Paul I. Robinson, vice president and chief medical director of Metropolitan Life Insurance Co. (New York City), will be the luncheon chairman, and Dr. John S. Pearson, medical director of American United Life Insurance Co. (Indianapolis), will be the afternoon session chairman.

Other featured speakers include Howard A. Schneider, Ph.D., acting director of the AMA's Institute for biomedical research, and Dr. Albert L. Larson, vice president and chief medical director of the Travelers Insurance Co. (Hartford).

Dr. John O. Alden, medical director of Aetna Life Insurance Co. (Hartford), and Dr. Frederick J. Newirth, medical director of Fireman's Fund American Life Insurance Co., will discuss disability insurance—its underwriting and claims, and aspects of rehabilitation.

Abbott Markets Nuclear Instruments

Abbott Laboratories, North Chicago, Ill., is entering the nuclear instrumentation field with a line of diagnostic nuclear medical instruments specially developed for small hospitals, clinics, clinical laboratories and private physicians' offices.

Three new instruments for diagnosis of thyroid and blood disorders will be introduced this month, according to Dr. E. J. Matson, director of Abbott's Radio-Pharmaceutical Division.

"While many people think of nuclear medicine in terms of radiation therapy, we find that diagnostic use of radioisotopes is becoming increasingly significant, growing at an even faster rate than diagnostic x-ray," Matson said. "However, the cost and complexity of the instruments required has pretty well limited nuclear medicine to large hospitals and institutions."

"To make diagnostic nuclear medicine more practical for smaller hospitals, clinics and physicians' offices, we have utilized the micrologic, integrated circuit techniques developed for solid-state computers to build complete nuclear instrumentation systems into a single piece of equipment that is the smallest, lightest, easiest to use and most versatile apparatus available at its price," said Matson.

The new instruments are used to measure radiation from blood and body fluid samples containing radioisotope traces. Principal tests done this way are thyroid function, red blood cell mass, plasma volume and latent iron-binding capacity.

With external probes the instruments can also be used for measuring thyroid uptake of the patient directly, determining the location of the placenta of unborn infants and surveying suspected cancer sites.

Abbott Laboratories became a pioneer in radiopharmaceuticals in 1946, when the Atomic Energy Commission first released radioisotopes for general scientific use, and is a principal supplier of these compounds.

According to Matson, Abbott's entrance into the nuclear instrument field this month comes as a direct result of the demands of its radio-pharmaceutical customers that Abbott's professional representatives assist them in the selection of nuclear instrumentation.

The first three instruments in the Abbott line of nuclear counting systems, trademarked the LOGIC series, are the Model 101 well counter precalibrated to be used with all currently available medical isotopes without adjustment, the Model 111 well counter with adjustable settings and provision for external scintillation detectors, and the Model 121 scaler analyzer for use only with external detectors with digital output for external printers.

The individual instruments cost from $2300 to $2700 each, measure a compact 12-1/2 by 13 by 4-1/16-inches high and weigh 25 to 35 pounds.



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PMA Names Robins Board Chairman

E. Claiborne Robins, President of A. H. Robins Company, today was elected Chairman of the Board of Directors of the Pharmaceutical Manufacturers Association. Named Chairman-elect was John J. Powers, Jr., President and Chief Executive Officer of Chas. Pfizer & Co., Inc.

C. B. William Howell, President of Geigy Pharmaceuticals, was reelected Treasurer of the Association, whose 136 member companies provide 95 per cent of the nation's prescription drug products.

Robins succeeded Walter A. Munns, Chairman of the Board of Smith, Kline & French Laboratories, at the PMA Annual Meeting at Boca Raton, Fla.

The new PMA chairman began his career with the Robins company in 1933, when it had three employees and annual sales of $4,800. Today, it is a $100 million company with 3,200 employees. A graduate of the University of Richmond and the School of Pharmacy of the Medical College of Virginia, Robins also holds a Ph.D. degree in Pharmaceutical Science from the same college and a Doctor of Laws degree from the University of Richmond. He has received a number of awards for his contributions to pharmacy and has served the PMA in various capacities since its founding in 1958.

Powers is a graduate of Georgetown University and of the Yale Law School. He joined Pfizer in 1941 as head of the legal department. He has been a member of the Pfizer Board of Directors since 1949. Much of his career has been in the international field, where the company has achieved rapid growth, and he was Board Chairman of Pfizer's international subsidiary before being elected President of Pfizer in May, 1965. He is active in educational and civic affairs and has served as a member of both the PMA Board of Directors and the Board of the PMA Foundation.

George R. Cain, Chairman of Abbott Laboratories, and Richard M. Furlaud, President of E. R. Squibb & Sons, were elected new members of the Executive Committee of the Board. Other members are Robins, Powers, Munns, Howell, and C. Joseph Stetler, President of the Association.

Four new members were elected to the Board of Directors. They are Lewis F. Bonham, President of the Norwich Pharmacal Company; Charles T. Silloway, President of the CIBA Pharmaceutical Company; Fred A. Coe, Jr., President of Burroughs Wellcome (U.S.A.), Inc.; and Dr. James F. Bourland, Vice President of American Cyanamid Company.

AMA Slates San Francisco Program

Four general scientific meetings of wide medical interest will be included in the Scientific Program of the American Medical Association's 117th Annual Convention to be held in San Francisco June 16-20.

The four general sessions:

—Automobile Accidents, with participation by Sections on Orthopedic Surgery, General Surgery, Pediatrics, Physical Medicine, and Preventive Medicine, as well as the AMA Committee on Medical Aspects of Automotive Safety.

—Health Care Planning, with participation by Sections on Preventive Medicine, Diseases of the Chest, General Practice, General Surgery, Internal Medicine, and Military Medicine.

—Management of Infectious Diseases, with participation by Sections on Experimental Medicine and Therapeutics, Allergy, Diseases of the Chest, General Surgery, Pediatrics, and Preventive Medicine.

—Treatment of Advanced Malignant Disease, with participation by Sections on General Surgery, Gastroenterology, General Practice, Internal Medicine, Nervous and Mental Diseases, Pathology and Physiology, Colon and Rectal Surgery (formerly Proctology), and Radiology.

Regular scientific programs also will be presented by each of the 22 Scientific Sections, plus a program by the Section on Miscellaneous Topics. The latter program will include a full day session on smoking and health sponsored by the AMA Committee on Research for Tobacco and Health, and a full day session on neurological surgery in which the American Association of Neurological Surgeons will participate.

The entire scientific program will appear in the May 6 issue of the *Journal of the American Medical Association.*

The youngest exhibitors and official guests of the AMA at its Annual Convention will be two teenage high school scientists.

They will be chosen at the 19th International Science Fair in Detroit May 15-18 by members

of the AMA Council on Scientific Assembly. Competing with over 400 other finalists from every state and several foreign nations, the two top AMA winners will be named for the excellence of their studies and exhibits in the basic medical sciences.

During the Convention, they will exhibit their displays in the Scientific Exhibit and will be introduced as honored guests of the AMA to the House of Delegates, the Woman's Auxiliary to the AMA, and at the Scientific Awards Dinner.

The AMA has been participating in the International Science Fair for 13 years as part of its program to attract superior students to the study of the medical and health sciences.

AMA Auxiliary Sets Film Showings

An afternoon of continuous health education films including films on sex education, drug abuse, physical fitness and nutrition will be a new feature at the 45th annual convention of the Woman's Auxiliary to the American Medical Association.

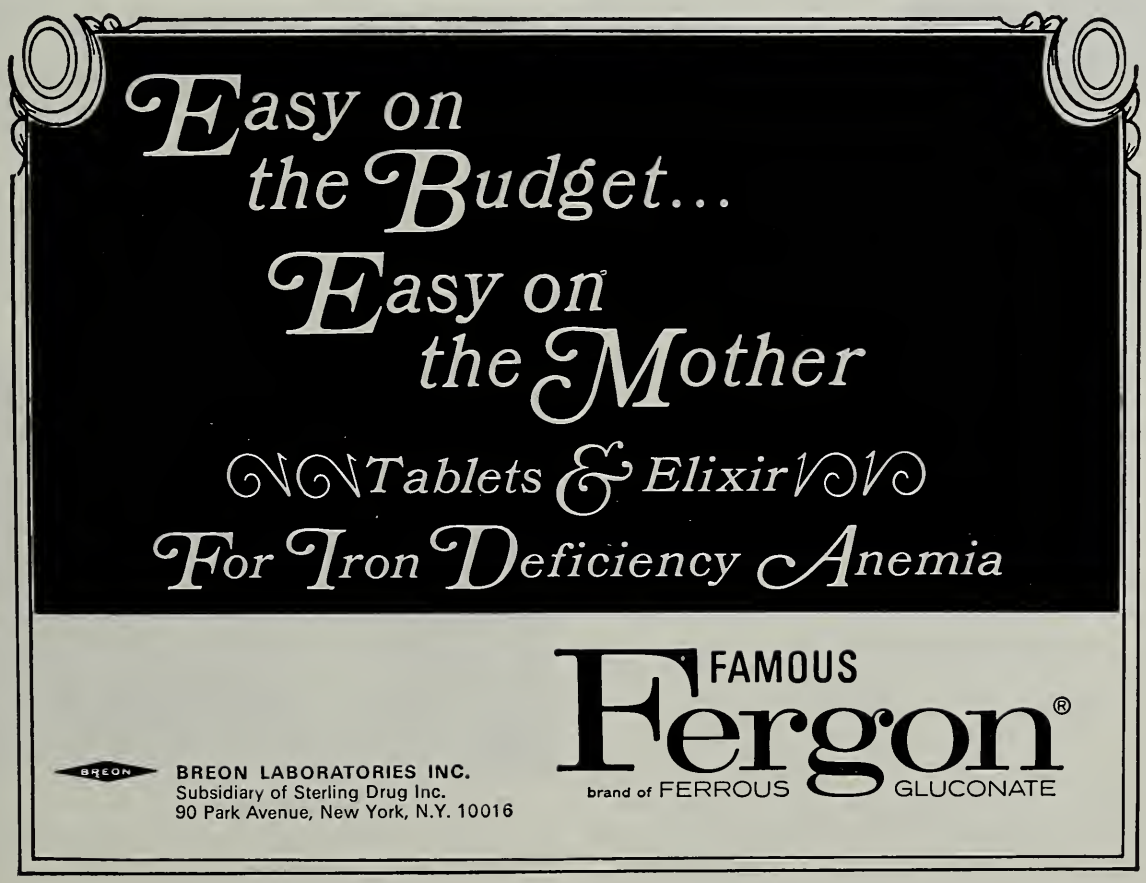
More than 2,000 physicians' wives are expected to attend the June 16-20 meeting at the St. Francisco Hotel, San Francisco, Calif. Auxiliary president, Mrs. Karl F. Ritter, Lima, Ohio, will preside.

On Sunday, June 16, the Auxiliary will hold a reception for their president, Mrs. Karl F. Ritter, and president-elect, Mrs. C. C. Long, Ozark, Ark., from 5 to 7 p.m.

Monday luncheon will honor the leaders of women's volunteer organizations throughout the United States.

Dr. Milford O. Rouse, AMA President, will be the guest speaker at the Tuesday luncheon honoring national Auxiliary past presidents and AMA Officers and Trustees and wives. At this time the Auxiliary will present its annual contribution to the American Medical Association Education and Research Foundation. Last year's gift totaled $384,649.48.

Following this luncheon, films will be shown for the remainder of the afternoon. This new feature will provide Auxiliary members with a catalog of available health education materials to be used in conjunction with existing Auxiliary programs.



The Auxiliary will also sponsor a program of daily activities for the pre-teens and teenagers of Auxiliary members. Local arrangements for the convention are under the direction of Mrs. Lloyd Gillin and Mrs. Don C. Musser, both of San Francisco.

Dr. Morgan Is Acting State Health Officer

Dr. Frank J. Morgan, Jr., of Jackson has been appointed acting state health officer following the sudden death of the executive officer, Dr. A. L. Gray. The action came at a special called meeting of the State Board of Health. The announcement was made by Dr. Joseph G. McKinnon of Hattiesburg, president of the board.



Dr. Morgan

Dr. Morgan is a native of Meridian who attended the University of Mississippi and Cornell University. He received the M.D. degree from the Tulane University School of Medicine and took his internship at Charity Hospital at New Orleans. He completed a five year residency in general surgery at Mercy Hospital at Vicksburg and the University Medical Center at Jackson.

After serving as director of the county health departments of Forrest, Perry, and Lamar counties, Dr. Morgan came to the State Board of Health in 1966 as executive assistant to the executive officer, the late Dr. Gray.

In making the announcement, Dr. McKinnon said that "due to the untimely death of Dr. Gray, the State Board of Health, with all members present, met for the purpose of initiating action for the selection of a qualified successor to Dr. Gray.

"Due to the importance of this position," Dr. McKinnon continued, "the board felt it wise to make no hasty decision. In the meanwhile, Dr. Morgan, who has been executive assistant to the executive officer for a period of two years, was designated executive assistant with full responsibilities in the absence of an executive officer and secretary."

Dr. Morgan said that "I am aware of and appreciate deeply the confidence placed in me by the Board of Health in selecting me as acting state health officer. With the assistance of our competent directors, supervisors, and county health officers, the programs of the State Board of Health will go forward without interruption during this interim period."

Dr. Morgan is a member of the Central Medical Society, the state medical association, and AMA. He has served as a naval flight surgeon and holds the grade of commander in the Naval Reserve Medical Corps.

MHA-UMC Sponsor Cardiovascular Seminar

X-ray diagnosis on inborn heart disease and use of computers in processing heart action studies were among topics getting close attention in the Mississippi Heart Association's March cardiovascular seminar.

Cosponsored by the University of Mississippi School of Medicine postgraduate education committee, the three-day course emphasized new techniques in the diagnosis and treatment of heart disease.

Among seminar principals were Dr. Alvan R. Feinstein, associate professor of medicine and epidemiology at Yale University School of Medicine; Dr. Thomas M. Blake, UMC associate professor of medicine and program coordinator; Dr. Gerold L. Schiebler, professor of pediatrics and chairman of the department at the University of Florida College of Medicine, and Dr. J. Scott Butterworth, associate professor of medicine at New York University School of Medicine.



Principals in the MHA-UMC cardiovascular seminar were, from the left, Drs. Feinstein, Blake, Schiebler, and Butterworth.



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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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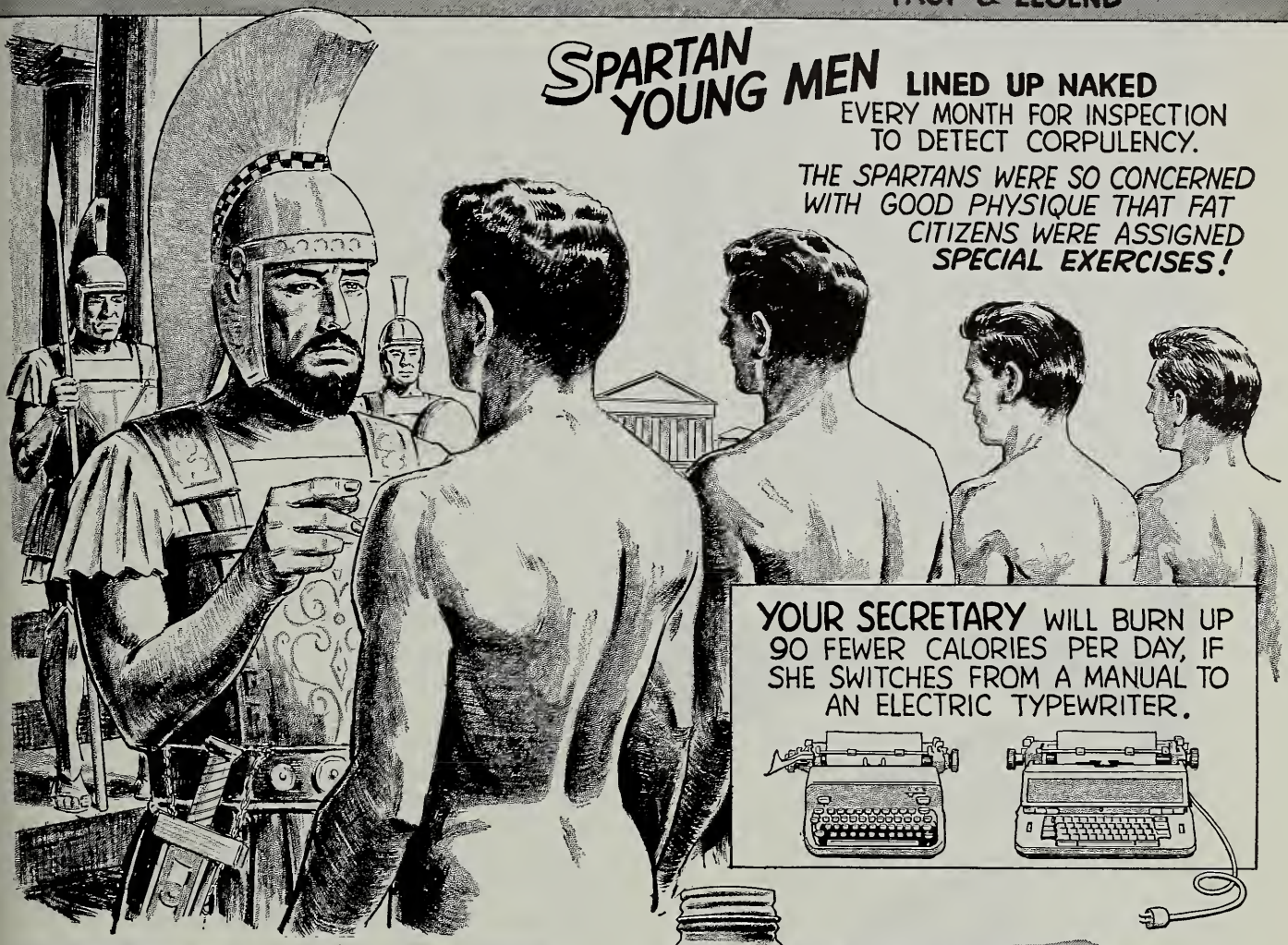
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Tufts Center Draws Charges of Waste

The Tufts University health center at Mound Bayou was called a "great waste of the taxpayers' money" by the director of the Bolivar County Health Department. Dr. Dominic Tumminello of Cleveland cited duplication of services regularly available through the county health department and lack of coordination by the OEO-funded project.

"If the $1.6 million (per year) they are spending were coordinated with the health department," Dr. Tumminello was quoted as saying by the Memphis *Commercial Appeal,* "a more far-reaching service could be provided the poor people in Bolivar County."

He pointed out that the poverty program project is building a new clinic in Mound Bayou, although "a clinic has been held regularly there for more than 30 years." He said that the Bolivar County Health Department has a system of clinics over the 917 square miles of the county which offer diagnostic, preventive, and maternity services.

The county health department has nine modern brick health centers in its area with the services of a public health nurse and medical director, Dr. Tumminello added.

The health department director hit hard at an article, "Grip of Poverty Chokes Mississippi Children," by *New York Times* staff writer Richard D. Lyons which appeared in the *Commercial Appeal* in April. The story depicted the sorry plight of a premature baby, carry photographic illustrations to drive home its point.

"The premature baby pictured in the article was delivered by a private physician," Dr. Tumminello said. "The baby's mother works for Head Start, and she attended the health department maternity clinic. The records shows that she desired the services of a private physician for her delivery."

He said that if the prematurity had been reported to the health department, one of seven electric incubators could have been provided and that a public health nurse would have been assigned to the case. He said that the baby could have been admitted to the hospital under the Bolivar County Project on Maternal and Child Care which is operated and funded through the Mississippi State Board of Health.

Dr. Tumminello was also quoted as saying that the Tufts project has qualified physicians who can serve a need, but he emphasized the oppor-

tunity for coordination of services against duplication and waste of tax funds.

The Tufts project is funded through a direct federal grant from the Office of Economic Opportunity, and it is not endorsed by the local medical society or the state medical association.

HIC Lists Health Planning Agencies

A state-by-state breakdown of health planning agencies has been issued by the Health Insurance Council.

The report, "Inventory of Community Health Planning Agencies," is a comprehensive listing of the major state and local organizations participating in community health planning. It was developed as part of HIC's Community Health Action Planning Program (HiCHAP).

It represents, according to Louis A. Orsini, HIC's director, "a useful contribution in the public interest by the insurance industry."

The listing shows that there are over 800 health agencies currently involved in aspects of community health planning.

The report's purpose is to identify key leadership in community health planning as an aid to organizations now a part of the nation's Partnership for Health program.

"Inventory" is the first such report of its kind. Information is given about many organizations including:

—Department of Health, Education, and Welfare public health service regional offices. Included are the names of the regional health directors and a listing of states within their jurisdiction.

—State health departments, which are generally the standard-setting agency for health services and facilities within a state.

—State mental health authorities in charge of centers offering in-patient and out-patient treatment, partial hospitalization, emergency services and consultation, and education to individual and group leaders in the community.

—Hospital and medical facilities construction agencies which are responsible for surveying needs and developing plans for construction of state hospital facilities.

—State comprehensive health planning agencies, which conduct statewide health planning and determine the flow of Federal funds for health planning and service.

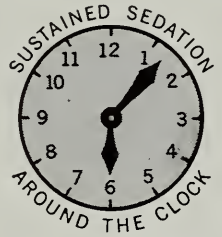
"Inventory" also lists state HiCHAP coordinators who do liaison and communications work on health planning for the private insurance business.

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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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Child Development Test Is Devised by PHS

A graphic new test has been devised to detect abnormal development in infants and small children, the U. S. Public Health Service announced today.

The new test, called the Denver Developmental Screening Test, is simple to administer, easy to score, and can be used for repeated evaluations of the same child. Developed under a National Institutes of Health general research support grant, the new screening tool has been recommended to the nation's pediatricians by the American Academy of Pediatrics and is now being used in Project Head Start.

Under the test format, an individual child's performance can be compared quickly with other children on a standardized scale for four major functional areas: gross motor, fine motor-adaptive, language, and personal-social.

The new test is not an intelligence test, according to developers Dr. William K. Frankenburg and Dr. Josiah B. Dodds of the University of Colorado School of Medicine. It is intended mainly as a screening device to detect children with developmental delays.

"It enables the examiner to note whether the development of a particular child is within normal range," said Dr. Frankenburg. "The test does not enable one to make a diagnosis; it is intended only to alert the examiner to the presence of a developmental problem which needs further investigation. Of course, when developmental delays are detected during infancy and the preschool years, it significantly increases the opportunities for effective therapy."

The new test is made up of 105 test items selected from a number of developmental and preschool intelligence tests. These items were administered to 1,036 healthy Denver, Colorado, children between the ages of two weeks and six years. The ages at which 25, 50, 75, and 90 per cent of the children passed each item were calculated for 25 different age categories. In the final screening test, which resulted from the normative data gathered by the investigators, each item is represented by a horizontal bar placed along the age continuum. Various points on the bar illustrate the specific ages at which a percentage of the children passed an item. For example, for the test item "Walks Well," the left-hand end of the bar designates the age (11.2 months) at which 25 per cent of the children could walk well and the right-hand end of the bar the age (14.3 months) at which 90 per cent of the children could walk well.



NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

June 1968

Dear Doctor:

Governor Nelson Rockefeller telegraphed his punches before a Senate committee last week as to what he would do on health care, if president. He testified in favor of national compulsory health care for all citizens as a "solution" to rising medical and hospital costs.

> Biggest surprise of hearings before the Ribicoff committee was a similar expression from a top insurance executive. Olcott D. Smith, chairman of Aetna's board, also testified in favor of compulsory programs, saying that private insurance could work with government in administering tax-supported compulsory care.

A courteous controversy is stirring in neighboring Alabama over a memorial cancer clinic in honor of the late Governor Lurleen Wallace. A lay group is promoting a $15 million facility as a "courage crusade," but it has no support from Governor Brewer nor the Alabama Division of the American Cancer Society. A new cancer facility has already been included in University of Alabama's $400 million expansion program.

The enigmatic Food and Drug Commissioner, Dr. James L. Goddard, caught almost everybody flatfooted with his resignation last week. For two years, he was a thorn in the side of the pharmaceutical industry over safety and efficacy of drugs as well as marketing requirements. He was quoted as saying that he wasn't pressured out but was just tired of it all.

The American Heart Association headlined a recent bulletin with "heart transplant trials are justified." Underlying reason, says AHA, is extensive research in laboratory animals and transplantation of other organs in human beings. Statement recognized high risk aspects of procedure.

Al Capp, creator of Lil Abner, and the ubiquitous Harold Stassen got one vote each for president and vice president at the recent SAMA convention. Over a thousand delegates, representing students in 91 medical schools, in presidential straw polling named Sen. Eugene McCarthy by a three-to-one margin on the Democrat side and Rockefeller over Nixon by two-to-one for the Republican choice.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Alaska Begins Tobacco-Health Education Program

Anchorage - An unprecedented tobacco and health education program has been instituted by Alaskan education authorities in the elementary schools. Reason: A recent survey showed that teenagers who smoked took up habit as early as the third grade, and 80 per cent did not know smoking cigarettes was harmful. Survey further showed that not a single smoking student was among those with straight A averages.

Mr. Nader: From Automobiles To Medicine

New York - Ralph Nader, author of the controversial book, Unsafe at Any Speed, on auto safety and lack thereof, has published an article in Ladies Home Journal, not known for its friendship to medicine, on hazards of x-rays. Article alleges that "90 per cent of all medical radiation is unnecessary." AMA has countered with an article in June Today's Health which will be useful to physicians in answering patients' questions on LHJ charges.

Cohen Disclaims Goal Of Compulsory Health Care

Washington - Testifying before a Senate committee in May, Secretary-designate of HEW Wilbur Cohen, chief architect of Medicare, said that he really doesn't favor universal and compulsory health care nor would he want to extend Medicare beyond proposed inclusion of the permanently and totally disabled. He said that he did not propose for Social Security to cover "poverty" classifications of citizens, either. Questioning elicited that that he did support Wagner-Murray-Dingell bill during Truman administration.

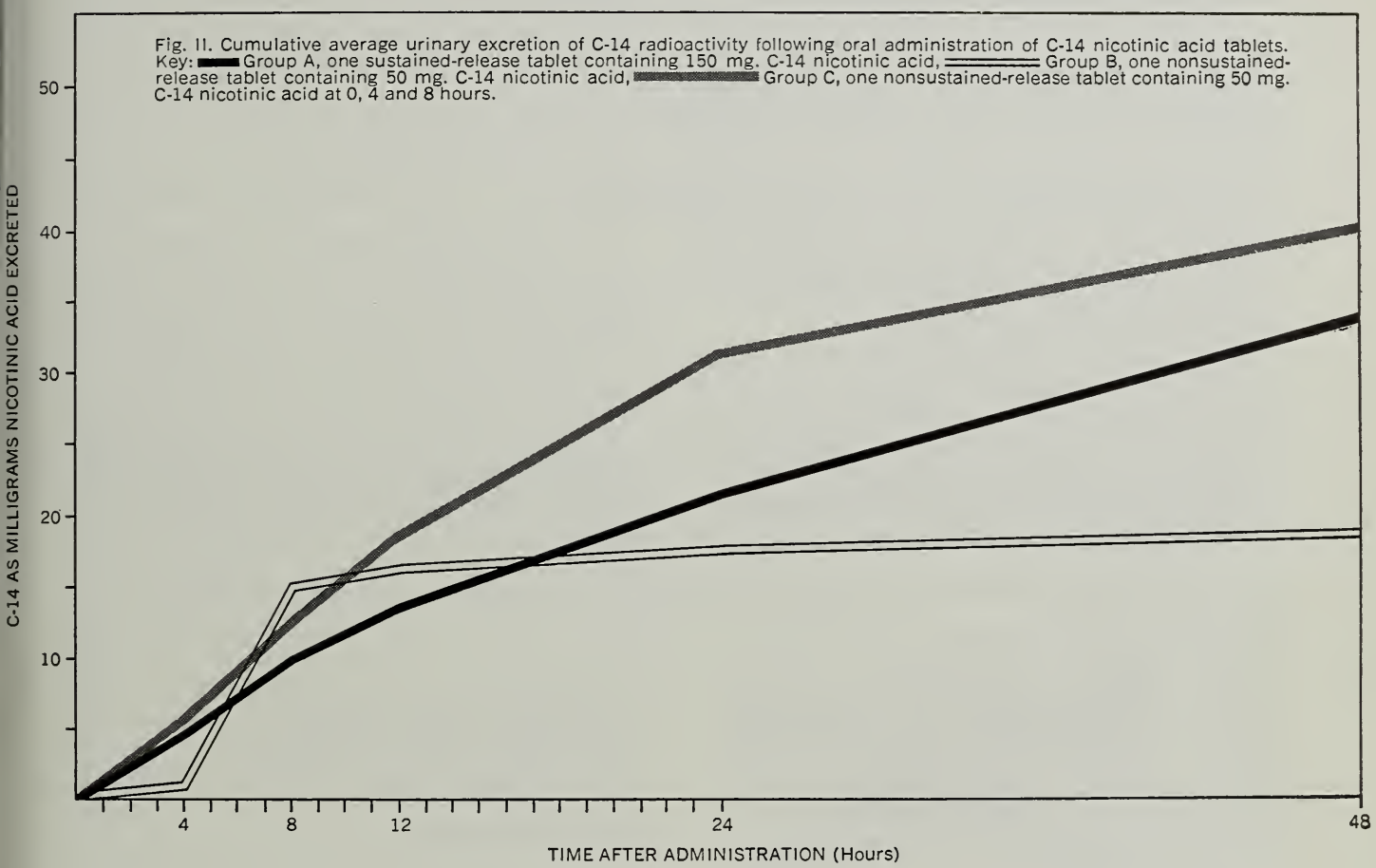
Kansas Tribunal Upholds Licensure Revocation For Incompetency

Topeka - A ruling by the Kansas Supreme Court may be a landmark decision in revocation of medical licensure for incompetency. A physician was barred from practice by the state board of medical examiners for "extreme incompetency" in surgery, but a circuit court set the ruling aside, but Supreme Court said that a lower tribunal may not substitute itself for a board of medical examiners who are fully qualified to say what constitutes competent medical practice. Citation is Kansas State Board of Healing Arts v. John J. Foote, M.D., 438 P. 2d 828, Jan. 27, 1968.

APHA Will Consider Urban Health

New York - The American Public Health Association will feature urban health problems at its 1968 meeting, and association says that such problems are a major cause of unrest in the big city ghettoes. Program will also include touchy topics as politics of health planning and reorganization of health care delivery system.

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

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HRET Announces New Teaching Project

Teaching programs for ward clerks, food service workers, and housekeeping aides are now available for health care institutions from the Hospital Research and Educational Trust, an affiliate of the American Hospital Association.

Dr. Edwin L. Crosby, executive vice president of HRET, said the texts and visual aids in the teaching program are designed to simplify the training of subprofessional health care workers and also to standardize inservice training materials.

The teaching programs result from two years of experience by hospitals and other health care institutions in a nationwide program which aided in the training of some 8,000 subprofessional health care workers, Dr. Crosby said.

Each teaching program includes a student manual and an instructor's guide as basic texts, plus a visual aid training supplement. The texts are written in a style for easy comprehension. They are amply illustrated to enable students to apply what they learn to actual job situations.

The student manual subject matter covers the duties in each occupation, from the fundamentals to the more complicated tasks and advanced skills. The instructor's guide parallels the subject matter in the student manual but also includes special teaching aids such as lesson plan pages and a sample final examination.

Each visual aid training supplement includes overhead transparencies designed to key in with the most important concepts in the student manual and instructor guide. Two accompanying booklets explain how to use the overhead projector and how to correlate the transparencies to the text.

Transplant Permission Is Called Unusual

A murder victim's kidney was transplanted to an unidentified patient recently in New Orleans with the permission of the decedent's wife, but permission for the transplant, city officials said, was obtained under unusual circumstances.

It seems that Albert Elzey, 35, who died six hours after receiving a gunshot wound in the head, was allegedly a victim at the hands of his wife. Physicians performing the transplant visited Mrs. Elzey at the city jail to obtain the customary permission.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Coarctation of the Aorta Presenting as Hematemesis

WILLIAM M. McKELL, M.D.
Jackson, Mississippi

Two types of coarctation of the aorta are recognized: the infantile type, in which aortic narrowing exists between the origin of the left subclavian artery and the insertion of the ductus arteriosus; and the adult type, in which the narrowing is either at the site of or distal to the ligamentum arteriosum. They report a case illustrating the association of bacterial aortitis and aortic rupture distal to the coarctation presenting the clinical picture of peptic ulcer with hematemesis.

COARCTATION OF THE AORTA is not an uncommon lesion, being found as the cause of death once in every 1,550[7] to 4,000[6] routine autopsy series. Two types are recognized: the infantile type, in which aortic narrowing exists between the origin of the left subclavian artery and the insertion of the ductus arteriosus; and, the adult type, in which the narrowing is either at the site of or distal to the ligamentum arteriosum. In patients who survive infancy, the primary causes of death during the first three decades are aortic rupture, bacterial endocarditis or aortitis, and intracranial hemorrhage.

Aortic rupture occurs primarily at two sites, proximal to the coarctation, generally in the ascending aorta, and, less often, distal to the coarctation.[9] In a review of the literature there are found only five cases of rupture into the esophagus with exsanguination by hematemesis.[1, 2, 3, 4, 5] France *et al.*,[1] however, reported hematemesis occurring in seven cases. Because of the association of bacterial aortitis and aortic rupture distal to the coarctation presenting the clinical picture of peptic ulcer with hematemesis, it was deemed of interest to report this case.

CASE REPORT

M. C., UMC #164752, a 14-year-old boy, was first seen by the Medical Service at the University Medical Center on May 21, 1966. He had been in good health until two months prior to admission when he was hospitalized for low-grade fever and malaise followed in two weeks by migratory arthritis involving the left ankle and right knee. The diagnosis of rheumatic fever was made and for three weeks prior to his admission to the University Hospital he was treated with prednisilone, 20 mg., and aspirin, 1500 mg. daily. He was continued on this regimen, with bed rest at home, until the night prior to admission when he experienced the sensation that "something stuck in his throat" and began to vomit bright red blood. He was hospitalized, treated with intravenous fluids, transfused with two units of whole blood, and referred to the University Medical Center the

From the Department of Medicine, University of Mississippi School of Medicine.

following morning. His only complaints at the time of admission were left upper quadrant and epigastric "soreness."

There was no history of chest pain, dyspnea, pedal edema, easy fatiguability, pain or weakness of his legs. There was no previous history of heart disease, murmurs, rheumatic fever, or chorea. There was a past history of "asthma" in early childhood. He had had a tonsillectomy and adenoidectomy three years previously, but other than this had never sought medical attention.

FINDINGS AT EXAMINATION

He was a well-developed, well-nourished white boy who appeared acutely ill but was in no distress. The temperature was 99° F, the pulse 110, and the respiration 36. The blood pressure was 170/70 in the right, 165/80 in the left arm and could not be obtained in the legs. The femoral pulses were palpable, though weak, but no pulses were felt distally. Examination of the optic fundi revealed no evidence of hypertensive changes. The skin and mucous membranes were quite pale.

There was a regular cardiac rhythm with the point of maximum impulse immediately lateral to the left midclavicular line in the fifth intercostal space. There was a Gr iii/vi low-pitched holosystolic murmur heard best at the apex and also heard in lesser intensity along the left sternal border and in the axilla. There was a Gr ii/vi high-pitched systolic murmur, heard best at the tricuspid area and radiating over the liver. The second sounds were physiologically split.



Figure 1. A mass is seen in the left mid-lung field adjacent to the hilum. There is apparent cardiomegaly, however there is not full inspiration.



Figure 2. Dissected aorta showing coarctation, site of rupture, and surrounding hemorrhage and necrosis.

There was questionable splenomegaly and mild direct epigastric and left upper quadrant tenderness. His stool was light brown and negative for occult blood. There was a dry scaly rash, with mildly increased pigmentation from the mid-trunk down, which was thought to represent a variant of ichthyosis.

LABORATORY REPORT

Admission laboratory work showed a urine sediment to contain 10-20 white and 5-10 red cells per high-power field and white cellular, hyaline, and granular casts. The hematocrit was 24 per cent, hemoglobin 8.3 gm. per cent, WBC 22,000 mm^3 with 220 metamyelocytes, and 220 myelocytes. Serum urea nitrogen was 29 mg. per cent, creatinine 1.7, chloride 106 mEq/L, CO_2 combining power 22, potassium 5.2, and sodium 141. The serum glucose was 98 mg. per cent, total bilirubin 0.4; alkaline phosphatase 10 King-Armstrong units; thymol turbidity 3.0 units, total protein 5.7 gm. per cent with 2.9 albumin and 2.8 globulin; and the SGOT 70 units, with a negative cephalin flocculation. The C-reaction protein was four plus, ASO titer 500 todd units, and the latex screening test negative.

Chest x-ray on admission (see Figure 1) revealed equivocal cardiomegaly, and a mass density in the superior mediastinum with parenchymal stranding in the left mid-lung field suggesting compression of the lung. Electrocardiogram taken on admission revealed a sinus rhythm at a rate of 100, a PR interval of 0.16, and a QRS interval of 0.08. The tracing was normal except for sagging ST segments and low T voltage.

DIAGNOSTIC IMPRESSION

The initial impression of the admitting physicians was rheumatic fever and bacterial endocarditis, with steroid and aspirin-induced peptic ulceration. A transfusion with whole blood was begun, and he was gavaged with iced saline. During the gavage he suddenly vomited a massive quantity of bright red blood and aspirated. Immediately following the episode blood pressure and pulse became unobtainable. Resuscitation measures were begun, including endotracheal intubation, assisted ventilation, external cardiac message, blood transfusion being pumped into all four extremities, then intravenous sodium bicarbonate,



Figure 3. Dissected aorta and esophagus showing communication between them.

metaraminol, calcium chloride, and intracardiac epinephrine. All measures failed, and he died three hours after admission.

POST-MORTEM EXAMINATION

There was a marked constriction of the aorta just distal to the ductus arteriosus with a rather marked post-stenotic dilatation (see Figure 2). The aortic circumference proximally was 3.5 cm., in the constriction 1 cm., and distally 4.5 cm. Im-



Figure 4. Section of esophagus showing site of rupture.

mediately distal to the constriction on the right posterolateral aspect of the aorta was a 1.5 cm. laceration which opened into the esophagus (see Figure 3). On the aortic media, immediately adjacent to this laceration, were multiple small friable verrucae. There was extensive mural thrombus formation on the intimal surface of the aorta in the poststenotic dilatation and extensive hemorrhage and clot in the peri-aortic tissues.

BACTERIAL COLONIES

Sections taken through the aorta at the site of rupture showed fibrin thrombi with large colonies of bacteria, presumably coagulase positive *Staphylococcus aureus,* as this organism was isolated from post-mortem blood culture. There was intimal ulceration and necrosis with extensive adventitial necrosis and abscess formation. Early atheroma was seen proximal to the coarctation. The internal mammary and intercostal arteries were prominent and patent as was the ductus.

The heart weighed 290 gm. with the left ventricle measuring 2 cm. in thickness and the right ventricle 0.3 cm. The aortic valve was bicuspid and 5 cm. in circumference, and both coronary arteries arose from behind a single cusp. The other valves were apparently normal and no verrucae were noted on any of the four valves.

The lungs were grossly normal except for a 6×6 cm. area on the medial aspect of the left

upper lobe immediately adjacent to the post-stenotic dilatation, which was firm, friable and erythematous. Sections through this area showed extensive acute inflammatory infiltration in the alveoli and bronchi. On the anterior portion of the esophagus in its mid-portion there was a 3 cm. laceration which communicated with the aorta (see Figure 4). A tissue section from this area showed mucosal ulceration, extensive hemorrhage, and abscess formation in the muscularis and adjacent connective tissue. The stomach contained 1200-1300 cc. of dark clotted blood and there was black tarry material filling the bowel to the transverse colon.

The liver weighed 2,120 gm. and was rather congested. The spleen weighed 750 gm. and exhibited multiple wedge-shaped hemorrhagic infarcts, the largest of which measured 5 cm. in its greatest diameter. Sections through the spleen revealed extensive necrosis, inflammatory reaction, and large colonies of cocci. Both kidneys contained multiple hemorrhagic infarcts, the largest measuring 2 cm. in its greatest diameter. Sections through viable renal tissue showed glomerular adhesions and acute and chronic periglomerular inflammatory infiltration.

COMMENTS

Death is due to rupture of the aorta in approximately one-fourth of the cases of coarctation. In a review of 104 cases, Reifenstein *et al.*[6] found the terminal complications of this lesion to be rupture of the aorta in 23 per cent, an intracranial lesion in 11 per cent, bacterial endocarditis or aortitis in 22 per cent, congestive heart failure in 18 per cent, and "incidental" causes in 26 per cent. In general, aortic rupture occurs at two sites, by far the more common site is the ascending aorta; less commonly, as in this case, distal to the coarctation. The average age at time of rupture of the ascending aorta is 30.0 years, distally 19.1 years.[6]

Proximal rupture frequently begins as a dissecting aneurysm and would be expected because of the elevated systolic pressure proximal to the stenosis. The ascending aorta is often dilated and the wall thinned, frequently being the site of atheroma. Microscopically, frequently there is found focal medial degeneration and replacement of elastica by connective tissue.[7] There is also found hyaline and fatty degeneration which has been attributed both to pressure effects and to an internal weakness of the media, an interpretation supported by the extensive dissection following the initial tear.[8] Spontaneous rupture of the ascending aorta is the main threat in pregnancy in patients with coarctation.

Distal rupture is stated to occur both spontaneously and from bacterial aortitis.[9] The exact cause of spontaneous rupture is not known for certain. Bellet *et al.*[10] postulate a "jet lesion" in the descending aorta just distal to the point of coarctation resulting in localized weakening of the aortic wall with aneurysm production. Monckeburg[11] postulated traction aneurysms at the site of the ligamentum arteriosum. Zaslow and Krasnoff[12] reported one case of aneurysm of the aorta distal to the coarctation in which patchy areas of mucinous degeneration of the media were demonstrated. They postulated eddy formation just distal to the constriction resulting in weakening of the aortic wall and a gradual dilatation of the lumen.

PRESSURE AND VELOCITY

Another possible contributing factor is related to pressure and velocity in this distal area. "Lateral pressure," or pressure exerted on the walls of the aorta, is inversely proportional to velocity. With the reduction in velocity distal to the constriction, the pressure is increased. This would explain the post-stenotic dilatation. With further decrease in velocity causing continued increased pressure and dilatation, a vicious cycle could well be established.

As has been mentioned, infection with inflammation and tissue destruction will predispose to aortic rupture as in this case. This has been said to be due to medial involvement secondary to mycotic emboli in the vasa vasorum[13] or from extensions from the intimal infection of aortic endarteritis. The post-stenotic dilatation, atheroma, and deformity produced by the coarctation itself all would tend to predispose to the invasion of blood-stream bacteria. The aortitis may spread to neighboring tissues producing mediastinitis, bronchitis with lung abscess formation or it may predispose to rupture, both of which occurred in this case. Bicuspid valves have been reported to occur in as many as 85 per cent of patients with coarctation of the aorta.[14] The major importance of the bicuspid valve lies in its predisposition to bacterial valvulitis, but according to Reifenstein *et al.*[6] the presence of bicuspid valves was associated with no increased incidence of aortitis.

SUMMARY

This brief review seems to suggest that rupture of the aorta distal to a coarctation and rupture proximally are essentially two different entities. The former occurs in a younger age group and

is related to flow currents and infection; the latter, occurring in later years, is related to pressure and degeneration of the aortic wall. ★★★

2500 North State St. (39216)

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FLOWERS SAY IT BEST

A physician occupied his new clinic building and on the first day, he received flowers from a local colleague. He was incensed to note that the floral offering was a funeral spray. The doctor stopped by the florist's shop on his way to the hospital to complain.

"I'm sorry, doctor," retorted the florist, "but I am worse off over this than you are. On somebody's casket, there's an arrangement with a ribbon saying 'Good Luck in Your New Location.'"

Radiologic Seminar LXXIV: Hemophiliac Arthropathy

WILLIAM A. BRIGHT, M.D.
Jackson, Mississippi

SKELETAL LESIONS in hemophilia may be due to secondary changes as the result of hemorrhages into adjacent joints or to bleeding directly into the bones. Direct bleeding into the bones may be intra-osseous or subperiosteal hemorrhages. Intra-osseous hemorrhages produce radiolucent cyst-like cavities in the bones. Subperiosteal hemorrhages are rare and have the same appearance as subperiosteal hematomas of nonhemophiliac origin.

Bleeding into the joint is far more common than bleeding into the bones. After a hemarthrosis has occurred, the intra-articular blood may be completely resorbed, in which case no residual deformity will result. However, after incomplete resorption or recurrent hemorrhages, a chronic inflammatory reaction is set up in the articular tissues resulting in deformities, disability and sometimes ankylosis.

The joints most frequently involved are the knees and elbows which are more vulnerable to repeated injuries than other joints but any joint may be involved. Hemarthrosis commonly occurs during middle and late childhood.

The early radiographic changes are those of a joint effusion and sometimes the articular space will appear widened (Figure 1). After repeated hemorrhages or incomplete absorption the chronic irritation produces a permanently swollen joint with associated bony changes. The synovial membrane hypertrophies as well as the subsynovial connective tissue. In this manner the nutrition of the articular cartilage is impaired resulting in cartilage destruction. This is reflected in a loss of joint space. The articular ends of the bones are invaded by connective tissue, and irregular bony defects and marginal defects result (Figure 2). After complete destruction of the joint space, fibrous and finally bony ankylosis may result (Figure 3).



Figure 1. This patient had a recent onset of pain and swelling in his left knee. AP view shows tissue swelling due to a hemarthrosis with slight irregularity along the articular surface of the femur suggesting hemarthrosis in the past.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi School of Medicine.

Other late changes include an increase in density of the soft tissues and accelerated maturation of epiphyses in involved areas. The increase in density of the soft tissues is due to deposition of iron pigment from repeated hemorrhages. The accelerated epiphyseal growth is thought to be due to hyperemia secondary to the chronic inflammatory process.



Figure 2. This patient had a history of repeated hemarthrosis in the right knee. Radiograph shows slight narrowing of the joint space with marginal and articular surface erosions.

SUMMARY

1. The early radiographic change of hemophiliac arthropathy is periarticular soft tissue swelling due to hemarthrosis.

2. The late changes are the result of chronic inflammation due to repeated hemorrhages or incompletely absorbed hemorrhages. These consist of a permanently swollen joint, loss of joint space, marginal and articular bony defects and finally ankylosis, either fibrous or bony. ★★★



Figure 3. There was a history of repeated hemarthrosis and clinical evidence of ankylosis of the elbow. X-ray reveals bony ankylosis of this joint. There was also an intercondylar fracture of the humerus present.

2500 North State St. (39216)

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SOME COOKIE

And here is the latest fortune cookie message featured at the local Cantonese restaurant: "You will soon meet a beautiful brunette woman. You will give her money. She is our cashier."

The Physician and the National Library of Medicine

LEONARD KAREL, Ph.D.
Bethesda, Maryland

The National Library of Medicine, now the world's largest biomedical library, was established by Congress to further the advancement of medical and medically related sciences. In January 1964, a computer-oriented information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) became operational at the Library. The MEDLARS store of biomedical journal articles published since January 1964 now exceeds 550,000 and is growing at an annual rate of 180,000 articles, taken from nearly 2,300 journals. The use of MEDLARS and other library services are discussed.

When the National Library of Medicine was established in 1836 as the Library of the Surgeon General's Office (U. S. Army), the surgeon general was authorized to spend $150 for medical literature. Today, the library, located at Bethesda, Md., near Washington, in a five-story contemporary building which it has occupied since 1962, is regarded as the world's largest in biomedicine. Among its holdings of 1,300,000 items, in 70 languages, are 315,000 monographs, 310,000 bound journal volumes; 285,000 theses, 168,000 pamphlets, and 4,500 reels of microfilm.

The library provides 175,000 interlibrary loans annually, and of these, 160,000 are photocopies of journal articles not available at the requesting local library. Reference personnel answer 10,000 personal inquiries, 10,000 phone inquiries, and 2,000 mail inquiries each year. Requests for 100,000 library items are made by 25,000 to 30,000 persons who use the reading room each year.

The library is a major publisher of biomedical bibliographies; e.g., *Index Medicus, Cumulated Index Medicus, Bibliography of Medical Reviews, Biomedical Serials 1950-1960, Bibliography of the History of Medicine;* and *NLM Current Catalog.* Among other library publications are *Medical Subject Headings,* the thesaurus for *Index Medicus, List of Journals Indexed in Index Medicus, National Library of Medicine Classification,* and *Russian Drug Index.*

Known for 86 years as the Library of the Surgeon General's Office, the library was developed as both a national and an international resource by Dr. John Shaw Billings, librarian from 1865 to 1895. In 1922, it was renamed the Army Medical Library and in 1952 was again renamed, this time, the Armed Forces Medical Library. In 1956, under legislation introduced by Senators Lister Hill of Alabama and John F. Kennedy of Massachusetts, it was transferred to the Public Health Service, Department of Health, Education and Welfare, and named the National Library of Medicine.

The library was established by the Congress of the United States to assist in the advancement of medical and medically related sciences by the collection, dissemination, and exchange of scientific and other information important to the progress of medicine and of public health.

Towards fulfillment of its mission, the library (1) acquires and preserves books, periodicals, films, prints, and other library materials pertinent to medicine; (2) organizes these materials by appropriate cataloging, indexing, and bibliographic listings; (3) publishes and disseminates catalogs, indexes, and bibliographies; (4) distributes materials through interlibrary loans, photographic, or other copying procedures; (5) provides reference and research assistance; and (6) encourages, promotes, and supports activities to further the

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progress of medicine and of public health by strengthening existing services and developing new ones.

The Congressional mandate was strengthened recently when, on Oct. 22, 1965, President Johnson signed the Medical Library Assistance Act, Public Law 89-291 of the 89th Congress. In signing the act, the President commented that the nation's medical libraries are a vital link between medical education, practice, and research, and that too little attention has been given to the problem of collecting and sharing scientific knowledge.

The Medical Library Assistance Act is an amendment to the legislation authorizing the establishment of the library. The act permits assistance to medical libraries for construction and renovation, for acquisition and for improvement of resources, for training of medical librarians and other information specialists, for preparation of publications, for research in medical library science, and for the development of regional medical libraries. The act also authorizes traineeships, fellowships, and special scientific projects by individuals or institutions.

Administration of the Medical Library Act on behalf of the library is done by the library's Extramural Programs.

ROLE OF THE LIBRARY

The library today serves as the principal national focus of resources and programs for bettering communication in medicine and the health sciences and is encouraging the development of the existing system of medical libraries into a national medical information network. Beginning on July 1, 1967, the library will acquire the Public Health Service Audiovisual Facility in Atlanta, Ga. This facility will be renamed the National Medical Audiovisual Center and will coordinate a national program in biomedical audio-visuals.

Access to the collection is facilitated through an interlibrary loan program. When libraries request loans through medical library channels, the National Library of Medicine lends books within the United States and, worldwide, provides single copies of articles from journals which the requesting libraries do not possess and which are not available locally. There is no charge for this service or for other services except special photography.

The library collects materials comprehensively in some 40 biomedical subject categories and selectively in many related categories. The collection, in which are over 19,000 serial titles, is increased annually by 95,000-100,000 items. It is estimated that the library now stores 360 million pages, of which 85 million are pre-1870, and that at least 10 million more are being acquired annually.

MEDICAL HISTORY STACKS

Its History of Medicine Division alone has between 60,000 and 65,000 printed works bearing publication dates earlier than 1801. Included in the collection are an Arabic manuscript of the year 1094 on gastrointestinal disease; a collection of palm-leaf manuscripts from Ceylon, in Singhalese; works of Hippocrates and Galen; and letters written by George Washington, by Benjamin Rush, and by Florence Nightingale. Holdings also include 535 incunabula; 33,000 16th, 17th, and 18th century monographs; 1,600 17th century theses and pamphlets; 2,000 early American medical works; and an estimated 60,000 prints and photographs.

Efforts of conscientious, busy practitioners to achieve and to maintain awareness of the most recent medical discoveries and applications have often led to many and continuing frustrations. The increase in the volume of medical literature and in the number of users has not been paralleled by equivalent growth of medical libraries and of information storage and retrieval methods and facilities adequate to catalog, index, store, and retrieve literature for use of physicians, scientists, and others. Therefore, the library adopted computerization as a means of assisting, supplementing, and complementing traditional approaches to management of published biomedical literature and pioneered in the use of computers for storage and retrieval of bibliographic information.

In January 1964, a computer-based information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) became operational at the library.

MIRACLE OF MEDLARS

MEDLARS joins the professional experience of trained literature analysts and searchers with the processing capabilities of a high-speed electronic computer. The literature analysts, using terms selected from a thesaurus of approximately 7,000 terms, *Medical Subject Headings* (Part II of the January issue of *Index Medicus*), characterize each article by assigning to it a number of subject headings or descriptors. Indexed articles are entered into the computer and transferred to magnetic tapes for storage and for rapid retrieval. Currently, MEDLARS contains over 550,000 citations to biomedical journal articles

published since January 1964. About 55 per cent of these are in English.

MEDLARS has improved the quality of the library's monthly *Index Medicus* and has substantially reduced the time required for the production of other library bibliographies.

Index Medicus, a comprehensive, monthly subject-author index, now incorporates 180,000 articles annually from nearly 2,300 of the world's biomedical journals. At the close of each calendar year, MEDLARS compiles *Cumulated Index Medicus,* a complete listing, with cross-references, of the citations which were printed in that year's issues of *Index Medicus.* An abridged edition of *Index Medicus* for the personal use of physicians is being planned in cooperation with the American Medical Association.

(MEDLARS does not now include monographs, symposia, conferences, congresses, and proceedings not published in journals.)

The journals indexed in *Index Medicus* (approximately 2,300) are selected with the advice of an extramural committee whose decisions are made largely on the quality of the journal under consideration; however, care is taken to assure subject balance. Discussions of journals are based on prior knowledge of the journal and on inspection of the journal by committee representatives. In addition, the committee is assisted by advice from subject specialists. Comprising the present committee are physicians and scientists, medical editors, and medical librarians.

COMPUTER SEARCHES

MEDLARS makes possible rapid machine searches of biomedical journal literature to obtain answers to reference questions that cannot be handled expeditiously by manual searches. Machine searches which provide citations to medical literature in specific areas of interest are called "demand bibliographies."

MEDLARS is responding to more than 400 highly specific computer search requests monthly. These requests are coming chiefly from physicians, teachers, and researchers in medical schools, hospitals, universities, and federal research laboratories.

In addition to demand bibliographies, the library collaborates with professional societies and other professional organizations in the preparation of "recurring bibliographies"—formally published, widely distributed bibliographies in specialized subject areas of broad interest.

These recurring bibliographies are *Artificial Kidney Bibliography; Bibliography of Medical Education; Cerebrovascular Bibliography; Fibrinolysis, Thrombolysis, and Blood Clotting; Index of Rheumatology; Index to Dental Literature;* and *International Nursing Index.*

Although the library supplies the sponsoring organization with citations retrieved periodically from MEDLARS on film ready for offset printing, the publishing and distributing of the bibliography —on a non-profit basis—are the responsibilty of the sponsoring organization.

DEMAND BIBLIOGRAPHIES

At frequent intervals, generally monthly, the library selects from its demand bibliographies a few considered to be of general interest. Announcements of the availability of these bibliographies, called *NLM Literature Searches,* appear in *Journal of the American Medical Association, Public Health Reports, Journal of the American Dental Association, NLM News,* and other publications, including state journals. There is no charge for these *Searches.* Clinicians, educators, and researchers interested in receiving notices on new *NLM Literature Searches* may write to the Office of Assistant to the Director, National Library of Medicine, 8600 Rockville Pike, Bethesda, Md. 20014.

To enhance effectiveness of MEDLARS, the library has provided its computer tapes and programs to university-affiliated centers which can make computer-generated demand bibliographies available locally or regionally to qualified practitioners, educators, and researchers. Decentralized MEDLARS stations are now in operation or will soon be in operation at Harvard University, the University of Alabama, the University of California at Los Angeles, the University of Colorado, and the University of Michigan. Others are being considered, and as regional libraries, authorized by the Medical Library Assistance Act, are identified, they, too, will be provided with a MEDLARS search capability.

MEDLARS INTERNATIONAL

Two MEDLARS centers are in operation outside the United States. In the United Kingdom under a cooperative arrangement between the University of Newcastle-upon-Tyne and the National Lending Library for Science and Technology at Boston Spa, Yorkshire, demand bibliographies are provided by the Lending Library. In Sweden, literature references taken from MEDLARS tapes are being provided by the Karolinska Institutet in Stockholm.

Physicians wishing to obtain demand bibliographies are encouraged to seek the advice of local medical librarians on suitability of the inquiries and on the preparation of requests which will elicit the information sought. The use of *Medical Subject Headings, Guide to MEDLARS Services,* and an expression of specific interests will help avoid retrieval of irrelevant citations. Thus, a request specifying animal experiments will help to insure that citations on human studies will not appear in the bibliography; similarly, specifying a single age group will obviate retrieval on all age groups.

Citations may be arranged alphabetically by senior author, by journal title, by language, by subject headings, and by year of publication, and each citation can be printed with the descriptors assigned to it by its indexer. Although the computer can print bibliographies on 8½″ x 11″ paper or on 3″ x 5″ cards, usually the printout is provided on the less costly paper.

The elapsed time between receipt of a request and mailing of a bibliography is a function of the volume of searches requested. At present, elapsed time is about three weeks.

It is important to note that MEDLARS does not produce abstracts. It is also important to note that MEDLARS services are not provided for searches which can be conveniently and readily accomplished by the use of published indexes, handbooks, and other reference materials. ★★★

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FACE VALUE

A notorious forger was apprehended by the police after having papered the same bank with several bogus checks. During the ensuing investigation, the bank's officers discovered that the same teller, a young woman, had cashed every one of the worthless checks. Suspecting that she might be an accomplice, she was questioned by the police.

"Why did you continue to cash this forger's checks?" asked the police captain.

"Because," was the reply, "he looked so familiar."

Rheumatic Fever Program

ALTON B. COBB, M.D., and WILLIAM J. GILLESPIE, JR., M.D.
Jackson, Mississippi

Based on current statistics, it can be projected that there are at least 1,000 school age children per year in Mississippi whose life span will be markedly shortened by acute rheumatic fever. The authors discuss the State Board of Health's program of primary prevention designed to make available statewide rapid streptococcal culture service. They also discuss a program under which rheumatic heart patients certified to be in economic need may receive prophylactic Bicillin.

ACUTE RHEUMATIC FEVER is a late nonsuppurative complication of untreated or inadequately treated Group A betahemolytic streptococcal infection. All 50 types of Group A betahemolytic streptococci, in the absence of adequate therapy, can cause rheumatic fever and the attack rate may be as high as 30/1000 with one of the more virulent strains containing a significant amount of M protein which has antiphagocytic properties.[1, 2]

According to 1965 population estimates, there are 668,000 children in Mississippi between ages 5 and 17 years.[3] It is reasonable to assume that they have at least one clinical respiratory infection per year. Other data reveals that 20 per cent of all children in this age group who have a clinical respiratory infection during the fall, winter and spring months have a Group A betahemolytic streptococcal infection.[4] Based on these figures we can assume that there are at least 133,600 streptococcal infections among school age children annually. If the attack rate of rheumatic fever is as high as 30 per thousand clinical infections, we could expect to have roughly 4,008 cases of rheumatic fever in this age group alone.

This seems like a small number and with the rapid decline in the reported incidence of rheumatic fever during the past several decades, there is a tendency to believe that rheumatic fever is no longer a serious problem. However, when one considers that rheumatic heart disease still remains the most common cause of acquired heart disease in individuals under 40 years of age, it is time to review the problem in the light of current concepts. Since between 25 per cent and 50 per cent of the children with acute rheumatic fever develop chronic rheumatic heart disease, it can be assumed that there are at least 1,000 school age children per year who will have a markedly shortened life span. Suppose, for example, that there were 1,000 cases of paralytic polio in Mississippi per year. One can imagine what the public outcry would be. Rheumatic heart disease is at least as serious a disease, the difference being that a damaged heart is not outwardly visible as are the damaged extremities in polio.

With the above facts in mind, can we afford to play with statistics and hope that a given child or young adult will respond like the great majority (970 out of 1,000) and recover uneventfully without therapy? No one is able to predict from the clinical course which child will or will not develop acute rheumatic fever, and, consequently, accurate diagnosis and prompt therapy are mandatory for all patients.

At first glance, one would think that it would be fairly easy to completely eliminate rheumatic fever as a serious health problem during the next decade with the excellent, inexpensive diagnostic adjuncts and treatment available today. This is not the case for several reasons:

1. Approximately 50 per cent of the patients with rheumatic fever do not have a history of a preceding illness.

2. The general public does not understand the gravity of the situation and many of the children with clinically significant respiratory tract infections are never seen by a physician.

From the Chronic Illness Services and the Heart Disease Control Unit, Mississippi State Board of Health.

3. The diagnosis of acute streptococcal pharyngitis is impossible to make on clinical basis alone and many of the streptococcal infections go untreated or are not treated adequately.[5]

If it is true that rheumatic fever cannot be completely eliminated as a health problem during the next several years, what should be done to diminish the morbidity and mortality attendant to this disease? The present program of primary prevention at the State Board of Health is designed to make available state-wide a rapid streptococcal culture service to all physicians and dentists, and to public health nurses and school health nurses in rural areas. This service is made possible by using the relatively inexpensive fluorescent antibody technique for diagnosing Group A streptococcal infections.

Plastic tubes containing swabs are provided by the Public Health Laboratory for use in specimen collection. Silica gel is supplied in glass vials for desiccating specimens. Silica gel (blue crystals) is poured into test tube with the swab. Streptococci survive for longer periods of time on a dry swab. This is not true for many other organisms, and silica gel should not be used with specimens other than streptococci. Suitable mailing containers are also supplied for mailing specimens.

REPORTS TO PHYSICIANS

All positive culture reports are normally telephoned to the physician by noon on the day following receipt of the specimen in the laboratory. Negative results are reported in the routine manner by mail. This not only allows the physician to confirm his diagnosis but makes it possible, in doubtful cases, for him to withhold antibiotic therapy until the results of the throat cultures are available.

In persons who have had rheumatic fever in the past, the risk of a recurrent attack approaches 50 per cent (500/1000) following a streptococcal infection, and, for this reason, long-term prophylaxis for the secondary prevention of rheumatic fever and rheumatic heart disease is mandatory. Bicillin (benzathine penicillin G) is furnished by the health department, without charge to the patients certified by their physicians to be in economic need of free medication. In addition, the state and local health departments have a statewide network of regularly scheduled consultative heart clinics, and if there is any question regarding the diagnosis and/or need for prophylaxis, the physician may refer the patient to the one in his area. Information on this service may be obtained from any local health department or from the Heart Disease Control Unit in the State Board of Health.

SUMMARY

In summary, it is felt that the culture service is being effectively utilized by a number of Mississippi physicians. During the past year 13,133 throat swabs were submitted for identification, and 16.1 per cent of these were positive for Group A streptococci. This is obviously a small proportion of the number which ideally should be submitted for study.

In the field of secondary prevention of rheumatic fever and rheumatic heart disease the program is serving only a small proportion of those needing this service. At present there are 613 patients on long-term prophylaxis. In the future it is expected that both services will be more widely used and will prove to be of value in reducing the morbidity and mortality from rheumatic heart disease. ★★★

State Board of Health (39205)

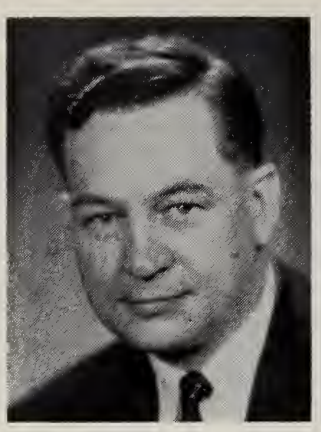
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POLITICAL FOWL

A chicken farmer running for Congress in a rural area was understandably upset when, at the height of the campaign, it was discovered that his son had been using marijuana. Worse than that, the son had gotten himself "on a trip" and given the stuff to the chickens which were staggering around the barnyard.

Not one to be caught at a disadvantage in a tight situation, the farmer-politician made a speech promising pot in every chicken.



The President Speaking

'Continuing Education'

JOSEPH B. ROGERS, M.D.

Oxford, Mississippi

THE CHALLENGE of tomorrow's medical generation is dramatized in the mighty effort being exerted to expand the nation's medical schools. The challenge of today, as we saw by fact and figure at our 100th Annual Session, is in continuing education for the practicing physician. Our Council on Medical Education has drawn a benchmark in its study, "Profile of Attainment—Measure of Need," and for the first time, we have a realistic appraisal of where we stand, what we wish, and what we can do in postgraduate medical education in Mississippi.

That the medical profession in Mississippi desires a formal, clinically oriented program of continuing education is clearly demonstrated in the study response which the council received. That this is a timely expression is made forcefully real by the council's assertion that the half life of current medical knowledge is less than 10 years, in view of the forward thrust and momentum of scientific advancement. But we have a lot going for us, too.

The profile of formal postgraduate training of Mississippi physicians shows up well, and our specialty groups equal or exceed their respective levels of attainment nationally. The generalist has given good account of himself, too. It is significant to note that the study found our state deficient—not in the quality of physician training—but in facilities through which programs of continuing medical education might be offered. In any program which we conceive and implement, we do so from this position of advantage, but we do not have the luxury of time in unlimited span.

Our neighboring states, Alabama, Arkansas, Louisiana, and Tennessee, are well ahead of us in postgraduate medical education opportunity, yet at least two, Alabama and Arkansas, are not now meeting their own respective needs. By defining our capacities, our needs, and our wishes in continuing medical education for physicians, we have made an important beginning. This is a subject to which we will address ourselves seriously in the months and years to come. ★★★

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EDITORIALS

Laboratory Medicine: It Keeps a Gentlemanly Cool

I

LABORATORY MEDICINE, in sheer economic terms, is a $1.5 billion component of the nation's outlay for medical care. But in a much more important context, it is the indispensable fulcrum for professional judgment in deciding upon diagnosis and treatment. The pathologist-operated clinical laboratory is a complex of special professional skills, knowledge, and diagnostic versatility. It is genuinely regrettable that the medical laboratory has become a storm center of public controversy brought about by a smoke screen of rigged statistics, blatant half-truths, twisted reports, and tortured logic. Now, the pathologists are answering back with a story which needs telling.

The College of American Pathologists, in a no-punches-pulled article in its *Bulletin,* has candidly assessed the charges and responded with admirable calm. Its spokesman is Dr. Bradley E. Copeland who has managed to keep a gentlemanly cool despite his having been disparagingly tagged the "pathologist apologist" by the general director of laboratories of the New York City Department of Health.

Dr. Copeland digs quickly into the heart of the matter, pinpointing Feb. 11, 1966, as the date when the attack on the medical laboratory was launched. He documents the growth of the charges during the two succeeding years by federal officials, reports, news stories, and editorials. And well might he have added the attacks in the halls of the Congress, resulting, at least in part, with the provision in federal law for licensure of medical laboratories. It reads almost as if it were a record of a tax court case: The pathologist was guilty until he could prove himself innocent.

II

Testifying in support of the budget provision for the National Laboratory Improvement Program in 1966, the Department of Health, Education, and Welfare said that "premature death, extended hospital stay, unnecessary suffering, and loss of productivity as well as tremendous economic losses are consequences of inaccurate laboratory results.

"It is conservatively estimated," the HEW testimony continued, "that at least 430 million tests are performed annually with an approximate error rate of 25 per cent. At an average cost of $4 per test, this represents a waste of some $430 million annually to the nation in payment for erroneous laboratory diagnostic results. The cost in human life and suffering is beyond monetary measurement."

That no documentation of the sweeping and grave indictment was presented with the testimony bothered neither the witnesses nor the subcommittee of the House of Representatives one whit. It should have been forcefully apparent that the occasion wasn't being brought off to give this segment of American medicine a fair shake.

The College reports that a direct result of this opening shot against laboratory medicine was the organization of a 17-member *Ad Hoc* Advisory Panel of the National Communicable Disease Center to study and report on a comprehensive program for improving the quality of services provided by clinical laboratories. The report went to a subcommittee of the House in April 1967, and it was more of the same.

"It has been demonstrated," said the CDC panel, "that serious deficiencies exist in the nation's clinical laboratories. Studies indicate that unsatisfactory performance is demonstrated by 10-40 per cent of laboratories in bacteriological testing. . . ." The old, unproved one-out-of-four error charge was repeated, and despite three members of the panel admitting that "none of the quoted figures is true and should not be permitted to pass for the truth," the report stood.

III

The CDC report contained 12 references in documentation which were something akin to accepting the testimony of the James brothers for each other's whereabouts on the night of the train robbery. Five of the references were from other CDC studies, another from a survey in New York, one from Canada, and two from surveys 15 and 20 years previously, respectively.

Moreover, the CDC surveys covered governmental laboratories, Indian Bureau hospitals, and federal prisons. Although the full thrust of the report was aimed at proving just how poor the nation's clinical laboratories were, the nation's clinical laboratories were not studied. This failure of probity and scientific integrity alone discredits the panel's judgment. As Dr. Copeland points out, it is not at all reasonable to extrapolate data from such limited surveys and take license to apply it to all of the clinical laboratories in the United States. Nor is it correct, he asserts, to imply that an error rate has been established for such common tests as urinalysis, blood hematocrit, serum calcium, or cytology studies.

The CDC documentation of alleged error in three major laboratory areas, blood banking, microbiology, and cytohematology, was taken *in toto* from Public Health Service surveys and New York laboratories. The panel was equally loose with the facts on mismatched blood transfusions, using data sometimes 20 years old.

IV

There is no specialty discipline in all of medicine which is more self-critical than pathology. By its very nature, it is probably the least subjective discipline, too, because the method and the result are there for all to see. No specialty imposes upon itself any tougher quality control measures than pathologists with the record showing that such were instituted for hematology, histopathology, and serology in the 1920's and 1930's; for blood banking in the 1940's; and for clinical chemistry in the 1950's.

The College of American Pathologists maintains a strict Laboratory Accreditation Program, and its Commission on Continuing Education makes certain that suitable materials, symposia, and other communications media carry the requirements into every pathologist-supervised laboratory.

The pathologist is well aware, Dr. Copeland says, that attending physicians realize the possibility of false negative and false positive tests and that final diagnosis and therapy seldom rest on the basis of a single test result. After all, the attending physician's decision is a composite judgment of his personal observations, his training and experience, and his evaluation of laboratory tests.

In fewer words, the pathologist is a reliable member of the professional medical service team.

V

The Mississippi State Medical Association has adopted the policy that the practice of pathology is the practice of medicine in every relevant sense. The association rejects any definition which suggests otherwise. And in the final legislative shootout, the Congress came to some notion of this definition, because in the laboratory licensure law, those laboratories directed by a certified pathologist or which have met the standards of nationally recognized pathologist and hospital accrediting agencies were declared exempt.

Dr. Oscar B. Hunter, Jr., of Washington, president of the College of American Pathologists, reminds us that these "untrue charges have been repeated and picked up as fact by various agencies and study groups." He, as does Dr. Copeland, asks only that the record be set straight as a matter of justice to the specialty. The JOURNAL deems this as much a duty and obligation—although never a line of such false reports has appeared in these pages—as it does a privilege. And it's worth repeating: The pathologists have calmly set the record straight while doing their job and keeping a gentlemanly cool.—R.B.K.

When it's more than a bad cold



your patient can feel better while he's getting better

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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription —prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Lederle

350-8

The Culpepper Resolution Comes of Age

It has been 14 years since the Culpepper Resolution stirred the American Medical Association House of Delegates, but its influence has been profound in American medicine. The resolution, bearing the name of the then-senior delegate to AMA from Mississippi, Dr. J. P. Culpepper, Jr., of Hattiesburg, drew sharp barriers against the practice of an institution billing for patient care and distributing the proceeds according to administrative wishes.

The resolution was the subject of study and debate for two years, and in 1956, guides were agreed to requiring the physician rendering the care to do the billing and also containing a stiff proscription against the corporate practice of medicine. A distinction is to be made between the Culpepper Resolution and the Hess Report, because the latter dealt exclusively with physicians and their relationships with hospitals, whereas the resolution dealt with institutions in practice for financial consideration.

Perhaps now an ultimate refinement to the principles established in 1956 has come about with the quite recent adoption of AMA's "Guides for Medical Staffs in Hospitals with Intern and Resident Training Programs." The guides aim at a dual purpose: To assure optimum circumstances in training programs and to set out precise groundrules for ethical billing and collecting for professional services involving teaching patients.

The guides urge all physicians on the staffs of teaching institutions to participate in the training programs. They enjoin the institution to leave the patient admitted to such an institution under the care of the admitting physician who, in giving care, with the patient's knowledge and consent, cooperates as far as possible with the training program. Finally, the guides exhort medical societies and hospital associations to engage in a combined program of education to insure a sufficient number of patients for medical training programs in accredited hospitals.

On the ethical side of the coin, the guides address themselves frankly to the problem of billing patients admitted to teaching services. They recommend that physicians of record collect fees for the care of these patients, as in the case of other private (and nonteaching) patients. Thus, hospital staffs or organizations representing hospital staffs may bill a patient for medical services on behalf of and only with the authorization of the attending physician.

The guides make it crystal clear that a hospital or medical school may not participate in the fees collected for medical services.

As to the distribution of funds so collected, the guides recommend that fees collected by or for the medical staff be distributed solely on the direction of the staff without coercion of any kind and in accordance with agreements previously reached by the physicians comprising the medical staff and the hospital or medical school. In addition, all members of the staff who render services should have an equal voice in determining the distribution of such fees. Full-time, salaried physicians may participate in these funds in proportion to the percentage of their total salary ascribed to actual patient care. A final caution in the guides suggests that staffs entering into such agreements seek appropriate advice concerning the legal and tax-liability implications of such arrangements.

There can be little doubt that the changing times since 1954 show up in the guides, not the least of which reflects the mushrooming growth of voluntary prepayment, health insurance, and government care programs. But there is a thread of consistency and a note of the original restraint which the Culpepper Resolution gives to the guides. The idea seems to have come of age.—R.B.K.

Longer Lives for Famous Men

If you are famous, then you may live longer. This is the surprising conclusion advanced by actuaries for the Metropolitan Life Insurance Co. who have made a unique study over the past 18 years.

Taking the 1950 edition of *Who's Who in America,* the actuaries extracted a sample about 6,300 prominent figures, representative of the professions and the business community. They comprised about a sixth of the prominent Americans listed, there being about 40,000 in that edition. Following these individuals closely for nearly two decades and carefully recording deaths, it was discovered that the famous enjoy notably longer lives than their less known male counterparts among whom were managers, professional individuals, proprietors, and public officials.

Those famous men in the 45-to-59 age bracket experienced only 55 per cent of the mortality of their obscure counterparts. Below age 45, the

difference was even more astonishing. As might be expected, it was discovered that the gap in mortality between the famous and the unknown tended to narrow in the advancing years.

It is easily understood how such a wide gap could have existed in the 19th century, because the famous were generally the privileged with more adequate diet, the advantage of the best medical care then available, environmental conditions of optimum sanitation, and probably less contact with most sources of communicable disease. It is also reasonably well established that this gap has been narrowing during the past half century, because a comparable mortality study made in Amsterdam during 1947-52 suggested that in a population with very low death rates, the differentials in longevity by social class tend to disappear altogether.

Of the groups studied by the life insurance experts, business executives and educators each represented a fifth of the sample. Physicians were less than one in 16, there being only 5.9 per cent of the listees in the 1950 *Who's Who* with the M.D. degree. The legal profession, heavily represented by judges and prominent attorneys, made up 9.3 per cent of the listings, while government officials (excluding the military) accounted for only 4.7 per cent.

The actuaries postulated an explanation for the gap by observing that the more favorable mortality rate among the famous "is believed to reflect in large measure their physical and emotional fitness for positions of responsibility." Sir William Osler was quoted as saying "to insure a long life, give a man a chronic disease." Now it looks as if fame will do just as well.—R.B.K.

Medical Education: Forward and Upward

The American Medical Association and the Association of American Medical Colleges have emphasized in a joint statement "the urgent and critical need for more physicians if national expectations for health services are to be realized." The two major health-related organizations have listed both immediate and long-range steps which should be taken.

Three immediate measures involve the increasing of medical student enrollment in existing schools, curriculum innovations and other changes in educational programs which could shorten the time required for a medical education and minimize costs, and encouraging diversification in the character and objectives of medical schools.

Long-range approaches logically involve the planning and establishment of additional medical schools, but generally speaking, this is a measure which will begin to pay off only after 1980. The statement speaks of construction programs, operational program support, and stimulation and incentive for further educational innovation and improvement.

From 1930 until 1947, only one new medical school was built in the United States. This is the gap, although the depression and World War II easily explain why it exists. From 1947 through 1968, 16 new medical schools have been opened and one osteopathic college has been converted into a medical school. In 1937, there were 77 schools of medicine in the United States, while there are 94 in 1968. By 1971, an additional 10 new schools will be in operation, making a total of 104. At least 20 more schools are in the planning stage.

In the past decade, M.D. graduates have increased more than 10 per cent, and the schools have enjoyed a growth of more than 8 per cent. Full-time faculties have grown by more than 65 per cent, and as might be expected in this era of boom and inflation, medical school expenditures are up by 176 per cent. There can be no doubting the direction of medical education in the United States today—it's forward and upward.—R.B.K.

POSTGRADUATE CALENDAR

FUTURE CALENDAR

September 13, 1968

PERITONITIS SEMINAR

This postgraduate education symposium will deal with problems related to various aspects of peritonitis. Guest lecturer will be Dr. Claude E. Welch of Boston, Mass., clinical professor of surgery at Harvard Medical School.

9:25 Welcome

9:30 Cardiovascular Dysfunction and Fluid Dislocations in Peritonitis
J. Harvey Johnston

9:50 Respiratory Complications of Peritonitis
Claude E. Welch



10:10 Renal Failure in Peritonitis
John D. Bower

10:30 Coffee

10:50 Special Problems Peculiar to Peritonitis in Pediatric Patients
Albert L. Meena

11:10 The Diagnosis of Peritonitis in the Unconscious Patient
Hilary H. Timmis

11:30 Radiographic Examinations in the Patient With Peritonitis
Robert D. Sloan

11:50 Discussion

12:00 Luncheon—River Hills Club

2:00 Peritonitis Secondary to Bile, Pancreatic, and Gastric Leakage
J. Harold Conn

2:20 Small Bowel Fistula
James D. Hardy

2:40 Inflammatory Intestinal Obstruction Resulting From Peritonitis
Edward M. Lowicki

3:00 Recess

3:20 Gangrenous Bowel Obstruction With Peritonitis
William O. Barnett

3:40 Management of the Patient With Peritonitis From Ruptured Colon
Claude E. Welch

4:00 General Discussion and Question Relating to the Peritonitis Problem

October 3-4, 1968

ARTHRITIS SEMINAR

Practical rheumatology will be emphasized during this two-day seminar presented under the auspices of the Mississippi Chapter, Arthritis Foundation and the University of Mississippi School of Medicine. Speakers will include Dr. Thomas E. Weiss of Ochsner Clinic and Dr. Charles R. Rockwood Jr. of the University of Texas Medical School. Orthopedists, radiologists and internists will complete the faculty. Program topics will be: low back syndromes, degenerative arthritis, polymyalgia rheumatica, cervical and thoracic outlet syndromes, shoulder girdle syn-

dromes and hyperuricemia and related syndromes.

October 15-17, 1968

MISSISSIPPI ACADEMY OF GENERAL PRACTICE

PERSONALS

FRED ALLISON, JR., formerly of Jackson, has been named the first Edgar Hull Alumni Professor of Medicine at the Louisiana State University School of Medicine. Scheduled to assume his new post this summer, he now occupies a chair as professor of medicine at the University Medical Center. During 1967, Dr. Allison spent a sabbatical year as guest investigator at Rockefeller University in New York.

OTTIS G. BALL and WAYMOND L. RONE of Jackson have been appointed clinical instructors in radiology at the University Medical Center. Each is in practice at Jackson.

GUY D. CAMPBELL, DURWARD L. BLAKEY, and FRANK J. MORGAN, JR., of Jackson will continue their respective terms on the board of directors of the Mississippi Tuberculosis and Respiratory Diseases Association. At the recent annual meeting, the association voted the redesignation from its old name, the Mississippi Tuberculosis Association.

WILLIAM C. KELLUM of Tupelo has been awarded the James D. Bruce Traveling Scholarship by the American College of Physicians. The award was made at the recent 49th Annual Session of ACP at Boston. Dr. Kellum, under the terms of the scholarship, will be engaged in postgraduate study in the coronary care units of the General Rose Memorial Hospital at Denver. During 1967-68, he served as chairman of the state medical association's Section on Medicine.

MAURY H. MCRAE of Corinth was honored by the Grand Lodge of Mississippi for 50 years as a master mason. He was presented with a certificate of honor and pin in ceremonies at the Corinth Lodge No. 116. Dr. McRae is a former worshipful master of the Corinth lodge, worthy patron of the Order of the Eastern Star, and adviser to the DeMolay Chapter.

GEORGE E. RILEY of Jackson, director of the Hinds-Rankin counties health department, was

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- CHRONIC BRONCHITIS
- BRONCHIECTASIS

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Phenobarbital, Caution: May be habit forming	21 mg.
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Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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honored by colleagues and fellow workers for 26 years' service in his present capacity. The occasion was a banquet. Dr. Riley, in addition to being a member of the Central Medical Society, the state medical association, and AMA, is past president of the Mississippi Public Health Association.

SHERROD R. TOWNS of Union Church was honored by his family and friends on the recent occasion of his 92nd birthday. An Emeritus member of the state medical association, Dr. Towns practiced actively for more than 50 years prior to his retirement.

BENTON Z. WELCH of Biloxi observed his 62nd year as a physician recently, having been at Biloxi since 1915. He is an Emeritus member of the association.

AAGP Issues New Practice Guide

A 105-page manual designed to provide the general or family physician with professional help in handling the complicated business aspects of medical practice and the important community and professional relationships involved has been developed by the American Academy of General Practice.

The manual "Organization and Management of Family Practice" attempts to fill an urgent need for expert advice in an area largely neglected by medical schools and professional organizations, states Dr. Raymond M. Kahn, chairman of the AAGP Committee on Medical Economics, which guided development of the manual. It is aimed at the graduate who wishes to avoid costly errors in establishing his first practice, and the practicing physician who wants to evaluate the efficiency of his present office procedures, Dr. Kahn says.

The illustrated handbook contains three major sections, including an introductory description of the content of family practice and the functions of the family doctor; a major middle section dealing with the business of running an office practice, and a third part describing the community resources and professional associations available to the practicing physician.

Members of the Society of Professional Business Consultants, a national association of business management consultants, were retained to study the unique problems of running a medical practice and to develop the 50-page middle section on Practice Organization and Management, Dr. Kahn noted.

This section provides guidance to the new physician on such vital decisions as what type of private practice to enter; what region, state and type of community will best satisfy his personal, professional and economic requirements for a practice location; how to select the ideal office layout, decorate attractively and functionally, and select expensive office, diagnostic and laboratory equipment.

In the area of office management, the manual offers detailed professional guidance as well as practical tips from experienced practitioners in selecting, training and keeping an effective office assistant; efficient record-keeping of patient clinical and financial histories and office accounting; establishing an efficient office appointment system, fee schedule and credit, collection and third party billing procedures.

Copyrighted models of the patient record forms, billing statements and office business forms discussed are reprinted actual size at the end of the section.

Two final chapters in the section deal with the professional and personal insurance desirable for private practice and the unique personal spending and investment problems of the private practitioner and his family.

The next to last chapter deals with the professional associations (hospitals, social welfare agencies, blood banks, nursing homes, pharmacies, etc.) and business contacts (management consultants, attorneys, banks, credit agencies, etc.) which every doctor must rely on. The final chapter discusses the services and programs available to family doctors through membership in such professional associations as the American Medical Association, American Academy of General Practice and local medical societies.

The manual is being made available to all Academy members. It also will be made available free of charge on request to medical students, interns, residents and medical school and hospital libraries.

Hattiesburg Society Names New Officers

The Hattiesburg Clinical Society has named officers for the 1968-69 year with Dr. J. P. Culpepper, III, as president. The group represents only Hattiesburg physicians and conducts regular scientific meetings.

Dr. David M. Owen has been installed as vice president, and Dr. Larry Smith is the new secretary-treasurer.

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

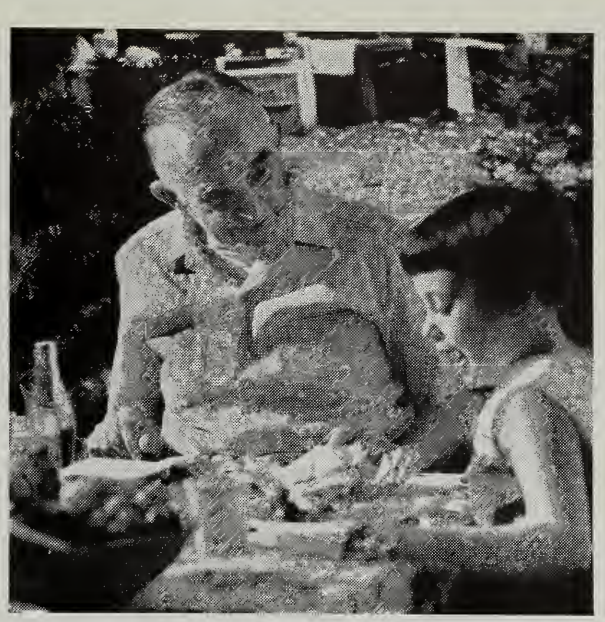
ADKINS, JERRY ROSS, Biloxi. Born Laurel, Miss., March 1, 1935; M.D., University of Mississippi School of Medicine, Jackson, 1960; interned U. S. Naval Hospital, San Diego, Calif., one year; general surgery residency, University of Mississippi School of Medicine, Jackson, four years; elected March 6, 1968 by Coast Counties Medical Society.

COWSERT, LOUIS ERNEST, Ocean Springs. Born Herrin, Ill., June 30, 1921; M.D., University of Illinois College of Medicine, Chicago, 1951; interned St. Francis Hospital, Evanston, Ill., one year; preceptorship, Union Hospital, West Frankfurt, Ill., three years; elected March 6, 1968, by Coast Counties Medical Society.

CRAIG, HARRIS VANN, Natchez. Born Jackson, Tenn., Aug. 31, 1935; M.D., University of Mississippi School of Medicine, Jackson, 1959; interned University of Oklahoma Hospitals, Oklahoma City, Okla., one year; general surgery residency, University of Mississippi School of Medicine, Jackson, two years; general surgery residency, University of Texas Medical Branch, Galveston, two years; clinical fellowship by American Cancer Society, one year; elected May 2, 1967, by Homochitto Valley Medical Society.

MANN, JOHN EVANS, JR., Jackson. Born Greenwood, Miss., July 6, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1966; interned Mississippi Baptist Hospital, Jackson, one year; elected March 5, 1968, by Central Medical Society.

ROBERTS, JOSEPH EDWARD, Jackson. Born Greenville, Miss., Jan, 8, 1931; M.D., Northwestern University Medical School, Chicago, 1956; interned, Erlanger Hospital, Chattanooga, Tenn., one year; internal medicine residency, Northwestern University Medical School, two years; cardiovascular fellowship, University of Mississippi School of Medicine, Jackson, one year; psychiatry residency, Tulane University School of Medicine, New Orleans, La., three years; member, Mississippi Psychiatric Association; elected March 5, 1968, by Central Medical Society.



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Pectin (2½ grains) 162 mg.
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Usual Adult Dose: One or two tablespoonfuls three times daily.

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Lederle Award Goes to UMC Faculty Member

Twelve medical school faculty members today were awarded grants by Lederle Laboratories for their dedication to medical teaching. They will share a total of $250,000.

The Lederle Medical Faculty Awards—established 15 years ago—are made annually to maintain the high caliber of medical education and to encourage medical teachers and investigators to remain in their disciplines. Today, there is an estimated shortage of nearly 1,400 full-time teachers in the 103 U. S. medical schools.

Lederle, a Division of American Cyanamid Company, has given nearly $9 million in the support of medical education, of which more than $4 million has been allocated to 216 faculty members.

This year's recipients include: Dr. W. Grady Smith, University of Arkansas; Dr. Jared M. Diamond, University of California, Los Angeles; Dr. Anthony P. Monaco, Harvard Medical School; Dr. Milton Diamond, University of Hawaii; Dr. Bernard Weiss, Johns Hopkins University; Dr. Joseph Wells, University of Maryland.

Dr. Aubrey E. Taylor, University of Mississippi; Dr. T. John Leppi, University of New Mexico; Dr. Ronald L. St. Pierre, Ohio State University; Dr. Steven Keresztes-Nagy, Stritch School of Medicine, Chicago; Dr. Jeanne Marie Lusher, Tulane University; Dr. Paul Bornstein, University of Washington.

The awardees are selected by an independent committee composed of seven leading medical educators who have full authority for selecting the recipients. Chairman of the committee is Dr. Maxwell Finland, who is George Richards Minot Professor of Medicine at Harvard Medical School.

Committee members include: Dr. Windsor C. Cutting, University of Hawaii; Dr. Harry F. Dowling, University of Illinois; Dr. Robert F. Pitts, Cornell University; Dr. George Sayers, Western Reserve University; Dr. Morris F. Shaffer, Tulane University; Dr. Douglas H. Sprunt, University of Tennessee.



Dr. Rogers Is Inaugurated President; Dr. Royals Is Named President-elect

Dr. James L. Royals of Jackson was named president-elect of the Mississippi State Medical Association at the history-making 100th Annual Session, and Dr. Joseph B. Rogers of Oxford was inaugurated president, succeeding Dr. Temple Ainsworth of Jackson who served during the 1967-68 year.

A new high in scientific programs was presented with closed circuit color television from the University Medical Center in addition to essayists and panels on the rostrum of the main meeting hall in the Heidelberg Hotel. The television was furnished by Smith, Kline, and French Laboratories of Philadelphia.

A smoothly-functioning House of Delegates acted on a heavy agenda of business with reports and resolutions.

In his address to the opening meeting of the House of Delegates, Dr. Temple Ainsworth placed heavy emphasis on medical care costs, the organization of the care delivery system, compensation of physicians, and fee review committees.



Three years of the association's presidency receive the gavel from House Speaker William E. Lotterhos, right. From the left, Drs. Temple Ainsworth, 1967-68 president, Joseph B. Rogers, 1968-69 president, and James L. Royals, president-elect.



Dr. Ainsworth congratulates Dr. Dwight L. Wilbur, AMA president-elect, who was featured guest speaker of the 100th Annual Session.

The president said that "on this day in 1968 when the newborn baby has an excellent chance of living 80 years in a state of good health, there is a note of irony in recognizing that the financing of medical care and the manner in which it shall be delivered are major questions facing our profession today.

"But a genuine concern for the unimpeded flow of quality medical care in the context of today's high state of the science must take into account cost factors. It must also consider the organization and means of delivery, because the four pillars of any free economy are production, finance, marketing, and distribution."



The Fifty Year Club was honored at the annual luncheon meeting, and its founder, Dr. W. H. Anderson, left seated, was inducted as a member. Dr. John B. Howell, Jr., chairman of the Board of Trustees, right standing, presided. Lower left, Dr. C. R. Jenkins and Dr. Hardy B. Woodbridge, Jr., general practice section officers, prepare for program. Right, Dr. Steven L. Moore and Dr. Frank J. Morgan, Jr., state health officer, discuss color TV presentations.







Nominating committee members look over slate: seated from the left, Drs. E. LeRoy Wilkins, Chairman B. B. O'Mara, and J. A. K. Birchett. Standing from the left, Drs. James O. Gilmore, W. H. Parker, C. B. Mitchell, Jr., Arthur E. Brown, and S. Lamar Bailey. Lower left, Dr. Charles N. Floyd, unhampered by his Colles fracture, is registered by staff member Donna Beech, as Speaker Lotterhos awaits his turn. Right, Drs. Howell, Ainsworth, Rogers, and Simmons hear reports in House of Delegates.







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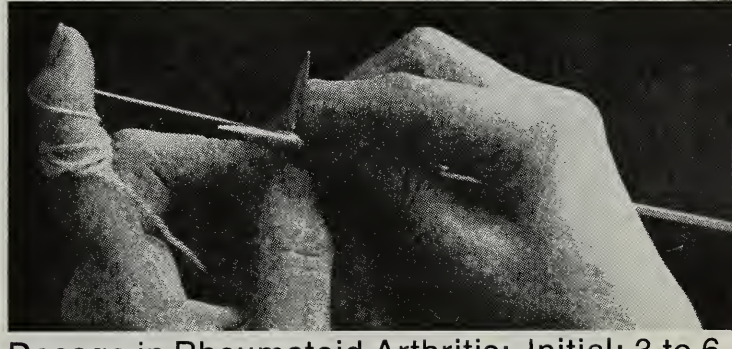
But don't forget this about Butazolidin alka

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-A

For complete details, please see full Prescribing Information.

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Dr. Ainsworth said that medicine is a profession, not a business, but the financing of medical care has been made a business for us, whether we like it or not. He placed emphasis on the role of government in care financing with Medicare, Title XIX, OEO health programs, and the many other government care endeavors.

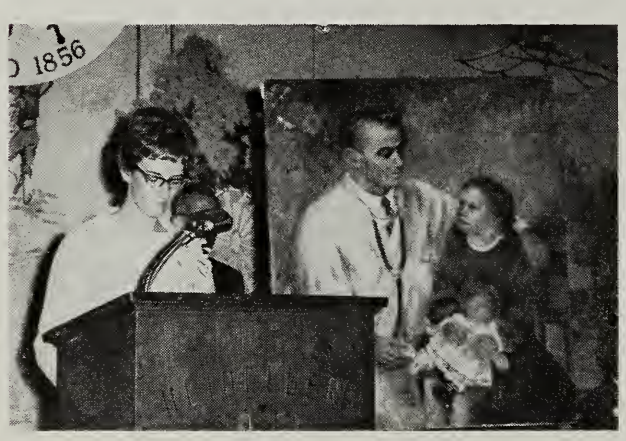
The president described compensation of physicians under the concept of usual and customary fees as "the most realistic development" in purchase of professional services.

"I recommend strongly that each component medical society of our association establish a fee review committee and that able, knowledgeable members be appointed to serve on each committee," the president said.

He urged that this important step be taken with the wholehearted support of every member of the association in the interest of securing proper and just remuneration for medical services.

Dr. Ainsworth called for "a workable, realistic, and just means of purveying medical care to all," and he declared that if our science is firmly positioned in the seventh decade of the 20th century, our philosophy ought also to be there with it.

The delegates unanimously approved the address, the fee review committee recommendation,



Mrs. David L. Clippinger, 1967-68 Auxiliary president, addresses the House of Delegates on meeting theme, "Painting the True Picture."

and gave Dr. Ainsworth a standing ovation after the reference committee enthusiastically commended his service as president.

The principal guest speaker, also appearing at the opening meeting of the House of Delegates, was Dr. Dwight L. Wilbur of San Francisco, president-elect of the American Medical Association.

Dr. Ainsworth, representing the Committee on American Medical Education and Research Foundation, presented Dr. Robert E. Carter, dean and director of UMC, with a gift of $11,473 of which more than $10,000 was given by Mississippi physicians and Auxiliary members.



Mrs. J. Gordon Dees, left, "Distaff" editor, and Mrs. Ralph Sneed, associate editor, show physicians display of Auxiliary's official publication.

New vice presidents named are Drs. Jack A. Stokes of Pontotoc, George H. Martin of Vicksburg, and C. R. Jenkins of Laurel. Dr. Martin was also re-elected associate editor of the JOURNAL.

Dr. Howard A. Nelson of Greenwood and Dr. Stanley A. Hill of Corinth were respectively re-elected delegate and alternate delegate to AMA.

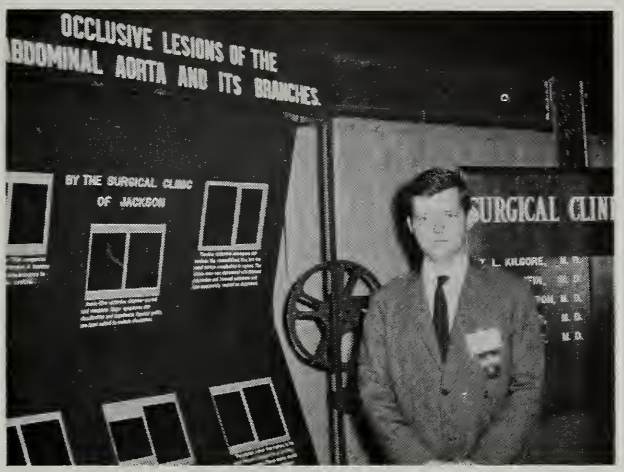
Two new Trustees were named in elections for Districts 4, 5, and 6, as Dr. Mal S. Riddell, Jr., of Winona was re-elected to a new three-year term. Dr. William O. Barnett of Jackson was elected District 5 Trustee, and Dr. Guy T. Vise of Meridian was named to the District 6 post.

Other elected and re-elected officials include Drs. J. T. Davis of Corinth, Council on Budget and Finance; William O. Barnett of Jackson, Council on Medical Education; and Raymond S. Martin of Jackson, Council on Constitution and By-Laws.

Named also to councils were Drs. John G. Egger of Drew, James L. Thornton of New Albany, and Frank M. Davis of Corinth, to the Council on Legislation; and Drs. Frank M. Acree of Greenville, Rhea L. Whatt of Holly Springs, and Arthur E. Brown of Columbus, to the Judicial Council.

Members of the Council on Medical Service named are Drs. Paul B. Brumby of Lexington, John G. Caden of Jackson, and William M. Gillespie, Jr., of Meridian.





Top left, Dr. W. H. Anderson, right, receives 1968 MSMA-Robins Award from President Ainsworth, as Robert North, A. H. Robins Co., assists. Behind president is Dr. S. J. McDuffie, secretary of winner's local society. Right, Dr. Thomas L. Kilgore, Jr., stands before his exhibit, judged best and winner of Aesculapius Award. Center, Dr. Rogers receives oath as president from Board Chairman Howell as Executive Secretary Rowland B. Kennedy holds association's Bible. Lower left, Mrs. Arthur E. Brown, second from left, presents certificates of award to Auxiliary AMA-ERF chairmen. Lower right, J. Somers Smith, Smith, Kline & French vice president, receives association's Scientific Achievement Award from Dr. Howell as Dr. Simmons observes.







The House of Delegates nominated five members to Governor John Bell Williams for a 1969 vacancy on the Board of Trustees of Mental Institutions: Drs. J. A. K. Birchett of Vicksburg, Eldon L. Bolton of Biloxi, C. P. Crenshaw of Collins, Martin E. Hinman of Vicksburg, and the incumbent, Victor E. Landry of Lucedale.

There will be no vacancy on the State Board of Health by reason of expiration of term of service in 1968, and the House, in a separate action, declined to nominate physician-directors for the Mississippi Hospital and Medical Service, Inc.

The four-day annual session was headquartered at Jackson's Hotel Heidelberg where more than a dozen specialty societies and four medical alumni groups conducted concurrent meetings. Attendance was 941, falling short of the expected 1,000-plus, and less than the 1,014 at Biloxi in 1967.

Harmonious House Acts on Big Agenda

A heavy agenda of 18 reports and six resolutions was handled smoothly during harmonious meetings of the House of Delegates at the 100th Annual Session. Principal items included Blue Shield in Mississippi, postgraduate or continuing education for physicians, the HEW project for the Mississippi Delta, creation of fee review committees, the chartering of a new component medical society, and a host of actions in the area of medical service.



Dr. Verner S. Holmes, president of Ole Miss Medical Alumni, congratulates Dr. Hector Howard of Memphis, president-elect of group.

Debate before four reference committees was conducted on the afternoon of the opening day, and final action came at the adjourned meeting at the conclusion of the annual session.



Section on Ob-Gyn officials are, from the left, Drs. J. Purves McLaurin, Jr., John E. Lindley, 1968 section chairman, and O. B. Wooley, Jr.

With only a single recorded "nay," the House of Delegates voted to endorse and support the action of the Board of Trustees in withdrawing association approval of the Mississippi Hospital and Medical Service, Inc., as a Blue Shield plan in Mississippi. The withdrawing of approval was authorized by an action of the House of Delegates at the 99th Annual Session in 1967.

The Board reported a series of meetings over 1967-68 on the issue of Blue Shield, including seeking the advice and counsel of the National Association of Blue Shield Plans which proposed a six-point compromise to establishing a new Blue Shield plan in the state.

The compromise called for the combination Cross and Shield plan to make a definitive separation by creation of a separate Blue Shield corporation, separate board of directors with the state medical association participating in the election of Blue Shield directors, separation of Cross and Shield funds into two treasuries with each plan self-sustaining, issuing separate contracts or a single contract with benefits and premiums of each plan separately and distinctly identified, continuation of present management reporting to the two boards of directors, and development of Blue Shield fees on a usual and customary basis.

The Board of Trustees reported rejection of points one and two, separate corporations and boards of directors by the plan after months of negotiation, calling the two points the "heart and substance of the proposal." Reporting that having no further alternatives to explore within the frame-



Top, Northeast Mississippi Medical Society delegation congratulates Dr. Anderson on winning MSMA-Robins Award. From the left, Dr. McDuffie, Mr. North, Dr. Anderson, Dr. Frank M. Davis, Dr. Stanley A. Hill, Mrs. Anderson, Dr. Jack Stokes, and Dr. Mary Ward. Lower left, the long and short of the Section on Surgery: Drs. M. Beckett Howorth, Jr., and Raymond S. Martin, Jr. Lower right, camera catches a serious moment as President Ainsworth addresses House of Delegates.





work of policies and objectives given it, the Board withdrew association approval on April 4.

The Trustees also reported that they did not make the decision to apply for use of the Blue Shield emblem and charter, stating that they will stand ready to work with the plan "in any serious effort to implement fully the six-point proposal of NABSP."

The Board also voted to furnish no further physician-director representation to the plan's board of directors.

The near-unanimous vote of the House of Delegates endorsed and supported the Board of Trustees' action and called for the investigation of the plan by the NABSP board of directors to proceed as begun after withdrawal of approval.

Reporting jointly, the Council on Medical Education and Board of Trustees presented a massive study report of postgraduate medical education in Mississippi entitled "Profile of Attainment—Measure of Need." The study report was distributed to delegates prior to the annual session.

A series of four recommendations growing out of the study was adopted, calling for the placement of priorities on continuing education for physicians, shaping of the program in accordance with their preferences, securing a voice in the program by the state medical association, and the establishment of a Mississippi Postgraduate Medical Institute as an adjunct to UMC.

Delegates called for continued representation on the nine-member committee developing a project for the Mississippi Delta under a proposed $2 million HEW grant. The program, now in planning stages, tentatively seeks intensified public health services, new training programs for anciliary medical personnel, and a limited outpatient health care program.

The proposal for fee review committees was adopted with the request of the reference committee that the Board of Trustees assist in the endeavor.

Authorization for chartering the Singing River Medical Society in Jackson County was given by the delegates after approval of a petition and application by the Board of Trustees, and the Secretary-Treasurer, Dr. Walter H. Simmons of Jackson, reported an increasing trend in membership.

In other actions, the House of Delegates:



Dr. Anthony J. Santangelo, 1967-68 president of the Mississippi Psychiatric Association, congratulates Dr. James F. Suess, new president. The specialty society had record attendance at its meeting.



Executive Board of Woman's Auxiliary meets at preconvention breakfast. President Clippinger is at lectern, and Mrs. Paul B. Brumby, new president, is seated third from left. Mrs. Louis C. Lehmann was named president-elect.

(Reprinted from Blue Cross-Blue Shield's current advertising campaign)



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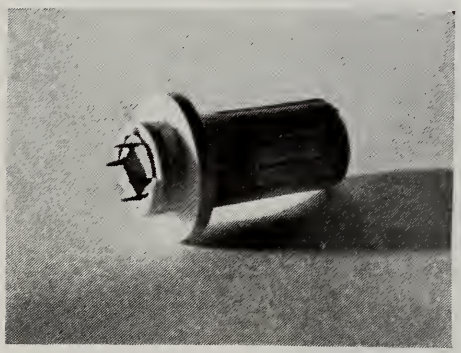
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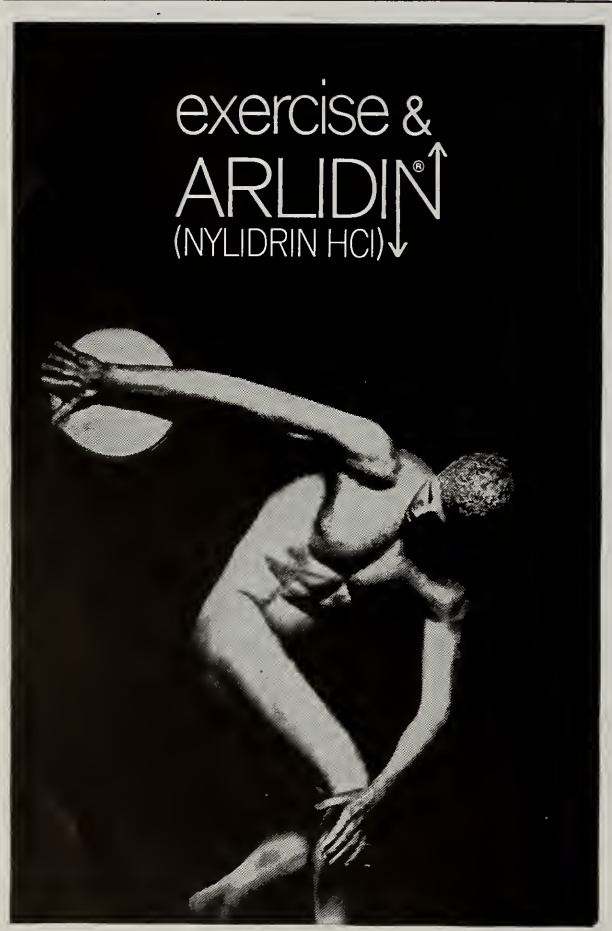


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—Noted that a Title XIX program would probably not be enacted by the 1968 Regular Session of the legislature, but asked that the association continue to seek enactment consistent with established policy.

—Reaffirmed approval of the emblem of the state medical association which was considered for change earlier in the year.

—Approved the work of the Council on Medical Service and noted the continuing decline in maternal mortality.

—Commended the series of utilization review conferences conducted in 1967, recognizing that future conferences may be conducted as needed.

—Agreed to survey each hospital in the state as to liaison established between the medical staff and hospital governing board as a follow-up to the 1967 recommendation that physicians serve on such boards.

—Concurred in a proposal to extend and expand emergency medical services.

—Directed the AMA policy on therapeutic abortion to the Council on Legislation for guidance purposes in reviewing proposed changes in the Mississippi abortion statute.

—Adopted a proposal to reaffirm approval of the standard AMA-HIC claim form for insurance purposes.

—Urged each component medical society and member to support statewide education and immunization programs against tetanus.

—Supported suggested legislation to require that coroners be licensed physicians.

—Sought repeal of a 1966 amendment to the public health laws placing an optometrist on the State Board of Health.

—Commended the Council on Scientific Assembly, the television chairman, Dr. William O. Barnett, and the six moderators for the excellent color TV presentations.

—Disapproved a resolution pending since 1967 which would have limited the terms of AMA delegates to six years or three consecutive terms.

—Declined to make a change in the By-Laws permitting appointment of reference committees by the speaker of the House of Delegates rather than the president.

—Provided complimentary subscriptions of the JOURNAL to members temporarily in the military service.

—Called for the Nominating Committee to select a slate of nominees three months before the annual session and publish the slate to the membership at least a month in advance.

—Deleted a provision of the By-Laws limiting nomination of a member for the State Board of Health for two consecutive terms only.



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Auxiliary Has Twin Bill Election at 45th Meet

The Woman's Auxiliary to the Mississippi State Medical Association conducted a twin election for naming its leadership for 1968-69, naming Mrs. Paul B. Brumby of Lexington the new president and Mrs. Louis C. Lehmann of Natchez as president-elect.

The double feature election was occasioned by the resignation last year of the president-elect named in 1967, Mrs. Herman E. Kellum of Vicksburg.

Also named to top posts at the Auxiliary's 45th Annual Session, meeting concurrently with the state medical association's 100th Annual Session, were Mrs. Curtis W. Caine of Jackson, first vice president; Mrs. Robert C. Tibbs, II, of Cleveland, secretary; and Mrs. David B. Wilson of Jackson, treasurer.

Mrs. David L. Clippinger of Hazlehurst served as the 1967-68 president and presided at the May annual session. Officials for the meet were Mrs. Raymond S. Martin, Jr., of Jackson, general chairman, and Mrs. Howard H. Nichols of Jackson, co-chairman.

Dr. Temple Ainsworth and Dr. Joseph B. Rogers, appearing during the meeting as the president and president-elect of the medical association, addressed the opening of the Auxiliary session.

Board of Trustees Names New Officers

The state medical association's nine-member governing body, the Board of Trustees, named Dr. C. D. Taylor, Jr., of Pass Christian as its new chairman, succeeding Dr. John B. Howell, Jr., of Canton who had served in this high post since 1964.

Named vice chairman was Dr. J. T. Davis of Corinth who succeeds Dr. Lamar Arrington of Meridian who had served in the second post since 1964.

Dr. Mal S. Riddell, Jr., of Winona was named secretary of the Board, succeeding Dr. Taylor.

Newly elected Trustees are Dr. William O. Barnett of Jackson, District 5, succeeding Dr. Howell, and Dr. Guy T. Vise of Meridian, succeeding Dr. Arrington, retiring District 6 member. Dr. Riddell was re-elected, and each of the three will serve three years.

Drs. Howell and Arrington were ineligible for re-election, because the By-Laws were amended in 1958 to limit a Trustee or council member to more than three consecutive terms of three years each. Dr. Howell served on the Board from 1955 until 1968, and Dr. Arrington served from 1941 until 1952 when he was president and again from 1958 until 1968. Together, they have 34 years of service on the Board.

Continuing to serve with terms until 1969 are Drs. W. E. Moak of Richton, District 7; Everett Crawford of Tylertown, District 8; and Dr. Taylor, the new chairman, District 9.

Serving with terms until 1970 are Drs. John M. Alford, Jr., of Greenwood, District 1; James O. Gilmore of Oxford, District 2; and J. T. Davis, the new vice chairman, District 3.

The chairman, vice chairman, and secretary make up the three-member Executive Committee of the Board. Regularly meeting with the Board but without the right of vote are the president, president-elect, secretary-treasurer, speaker and vice speaker of the House of Delegates, and the delegates to AMA.

Wisconsin Slates Oncology Conference

The University of Wisconsin Medical School division of clinical oncology will hold its eighth annual National Cancer Conference Aug. 22-24 at the Park Motor Inn, Madison.

The conference, "Cancer Chemotherapy '68," is open to all United States physicians interested in cancer chemotherapy.

The guest faculty will include: Drs. Emil Frei, III, associate director (clinical research), M. D. Anderson Hospital and Tumor Institute; Jesse Steinfeld, associate director, program, National Cancer Institute; Howard Skippa, assistant director, Southern Research Institute; Charles Heidelberger, U.W. professor of oncology, and Ovid Meyer, U.W. professor of medicine.

The rest of the faculty is from the division of clinical oncology, including Dr. Fred J. Ansfield, program director.

The division of clinical oncology is known for its work on experimental cancer drugs. Dr. Anthony R. Curreri, professor and chairman of surgery, is the director of the drug program.

Alcorn Doctors Sponsor Tetanus Shot Program

Physicians of Alcorn County sponsored a mass tetanus immunization program April 15 through May 8 aimed especially at adults. Corinth Mayor John D. Mercier proclaimed the three and one-half week period as official dates for the campaign.

Both booster shots and the toxoid series were offered without charge in physicians' offices during regular hours. The Alcorn County Health Department furnished the toxoid.

Sponsoring the project was the Alcorn County Medical Club, according to Dr. Frank M. Davis, president, who said that "the immunization is being offered to adults only as children are required to have the series before entering local schools.

"We are especially encouraging women to renew or begin protection," Dr. Davis continued, "since a number of men have received shots in the service."

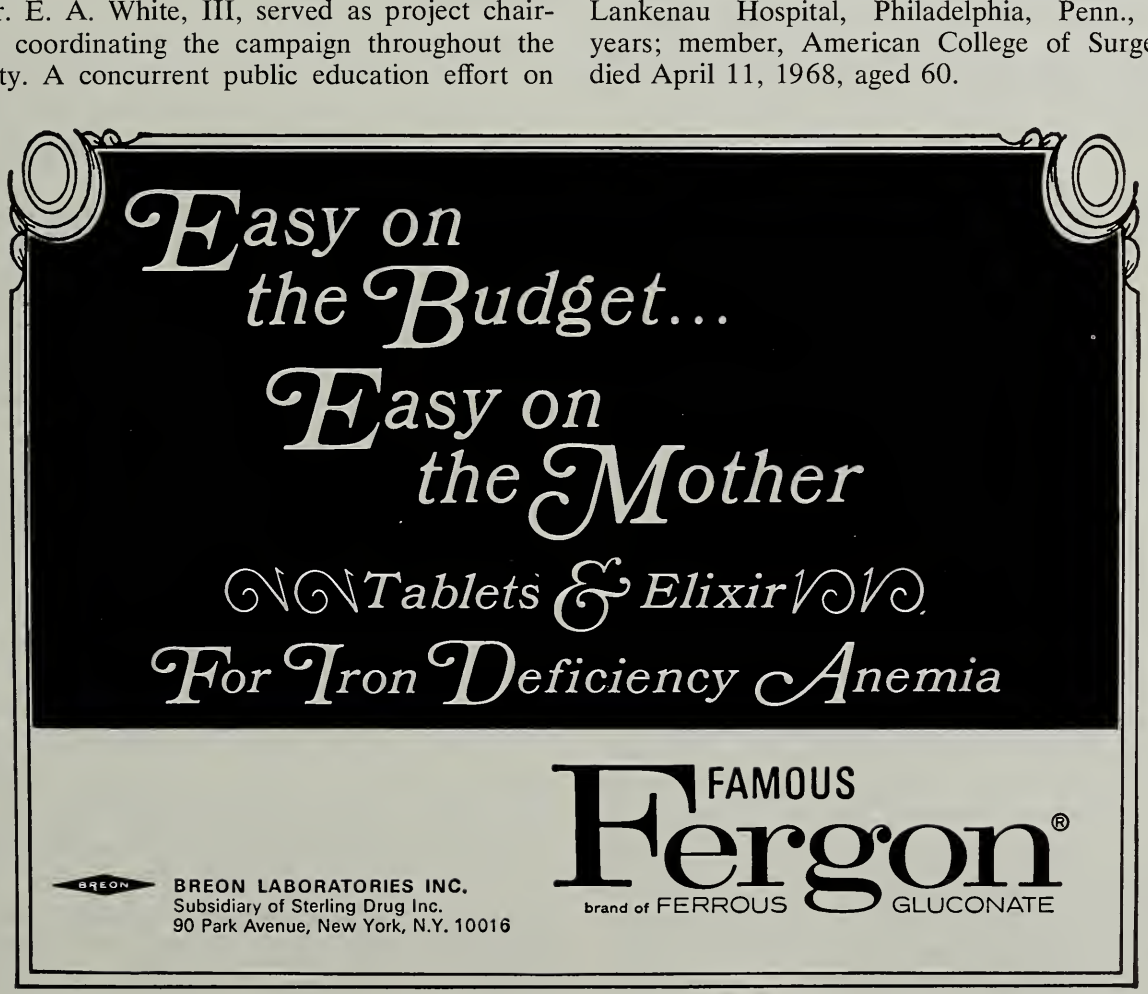
Dr. E. A. White, III, served as project chairman, coordinating the campaign throughout the county. A concurrent public education effort on tetanus and the need for immunization was conducted through the *Daily Corinthian*.

Participating in city hall ceremonies when Mayor Mercier issued the proclamation were Corinth physicians, including Drs. J. T. Davis, Dennis E. Ward, D. W. Hamrick, R. C. Wigginton, Dr. White, the campaign chairman, and Dr. Frank M. Davis, the club president.

DEATHS

EUBANKS, GEORGE WASHINGTON, Greenville, M.D., University of Tennessee College of Medicine, Memphis, 1909; post graduate training, Tulane University School of Medicine, New Orleans, La., three months; died April 20, 1968, aged 80.

KENDALL, NATHAN FULGHAM, Mendenhall. M.D., University of Pennsylvania School of Medicine, Philadelphia, 1930; interned Mobile City Hospital, Mobile, Ala., one year; residency, Lankenau Hospital, Philadelphia, Penn., two years; member, American College of Surgeons; died April 11, 1968, aged 60.



O and O Society Elects Leaders

Dr. Hugh H. Johnston of Vicksburg was inaugurated as president of the Mississippi-Louisiana Ophthalmological and Ototlaryngological Society at its recent Gulf Coast annual meeting headquartered at the Edgewater Gulf Hotel. Dr. Miles Lewis of New Orleans was named president-elect.

The long-time secretary-treasurer, Dr. Edley H. Jones of Vicksburg, retired from his post and was succeeded by Dr. Arthur V. Hays of Gulfport. Dr. Chester W. Masterson of Vicksburg served during the year as assistant secretary-treasurer.

Dr. Johnston succeeds Dr. F. W. Raggio, Jr., of Lake Charles, La., who served as the society's president during 1967-68.

In odd-numbered years, the society has made the practice of meeting on Friday and Saturday following adjournment of the Mississippi State Medical Association's annual session at the Gulf Coast.

PHS Initiates New Hospital Studies

The award of a contract for a hospital systems study at the San Francisco Public Health Service Hospital marks the first phase of the modernization program for that facility and the hospital system of which it is a part, according to Assistant U. S. Surgeon General John J. Walsh, Director, Division of Direct Health Services.

Dr. Walsh said the contract for an eight-month study, in the amount of $245,500, was awarded to H. B. Maynard and Company, Inc., Pittsburgh, Pa., in association with Kaiser Engineers, Oakland, Calif., the General Research Corporation, Santa Barbara, Calif., and health care delivery systems consultants drawn from the staffs of the Kaiser Foundation Hospitals, Oakland, and the Temple University Hospital-Health Sciences Center, Philadelphia.

The San Francisco facility is one of 10 general hospitals located throughout the nation operated by the Division of Direct Health Services. The other general hospitals are located in Baltimore, Boston, Detroit, Galveston, New Orleans, Norfolk, Savannah, Seattle, and on Staten Island, New York.

Dr. Walsh said, "The San Francisco hospital systems study reflects a commitment on the part of our division to introduce modern techniques of systems and industrial engineering as an integral part of the modernization of its patient care facilities. We believe that the use of these techniques is a necessary component of the effort to promote greater efficiency and effectiveness in the delivery of health services."

The San Francisco study will embody an interdisciplinary approach to the achievement of three overall objectives. They are the improvement of the hospital's operations, the improvement of its physical facilities, and the provision of a base for future research and development in hospital programs.

MS Society Offers 'Talking Books'

The availability of "talking books" for multiple sclerosis patients has been announced by the Central Mississippi Chapter of the MS society. These are recordings of current books made available through the Library of Congress.

Jessie Lynn Ruff of Jackson, chairman of the society's public relations committee, said that the recordings and players are available to patients, hospitals, and nursing homes without charge. The service may also be furnished patients with other conditions, provided disability criteria are met. Miss Ruff said.

To qualify, the patient must be unable to hold a book or turn the pages, have blurred or double vision, suffer from extreme weakness or debilitation, or have similar physical limitations.

The Central Mississippi Chapter will respond to applications from physicians, hospitals, nursing homes, or patients themselves. Letters may be addressed to the chapter at Box 10072, Jackson 39206.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Annual Convention, June 16-20, 1968, San Francisco, Calif.; Clinical Convention, Dec. 1-4, 1968, Miami Beach, Fla. F. J. L. Blasingame, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

American Academy of General Practice, Annual Meeting, Sept. 13-20, 1968, Las Vegas, Nev. Mr. Mac F. Cahal, Executive Director, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

Southern Medical Association, Annual Meeting, Nov. 18-21, 1968, New Orleans, La. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 101st Annual Session, May 12-15, 1969, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Mississippi Academy of General Practice, Annual Assembly, Oct. 15-17, 1968, Biloxi. Miss Louise Lacey, Executive Secretary, P. O. Box 1435, Jackson 39201.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. S. E. Field, Jr., Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. William O. Barnett, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 668, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday Quarterly, Jefferson Davis Memorial Hospital, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Second Wednesday March, June, September, and December. Herbert R. Power, Vaiden Clinic, Vaiden, P.O. Box 85.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday every month. J. M. Howell, 215 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

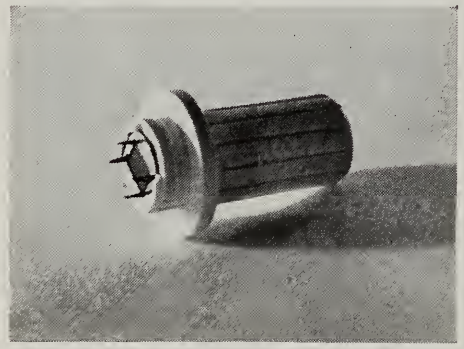
South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, P.O. Box 1230, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, 1513 Clay Street, Vicksburg, Secretary.

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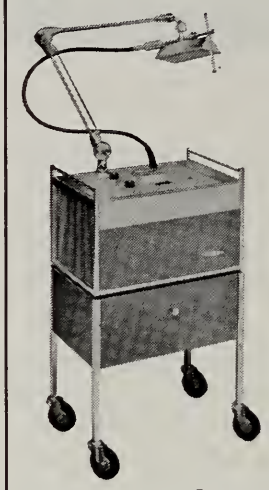
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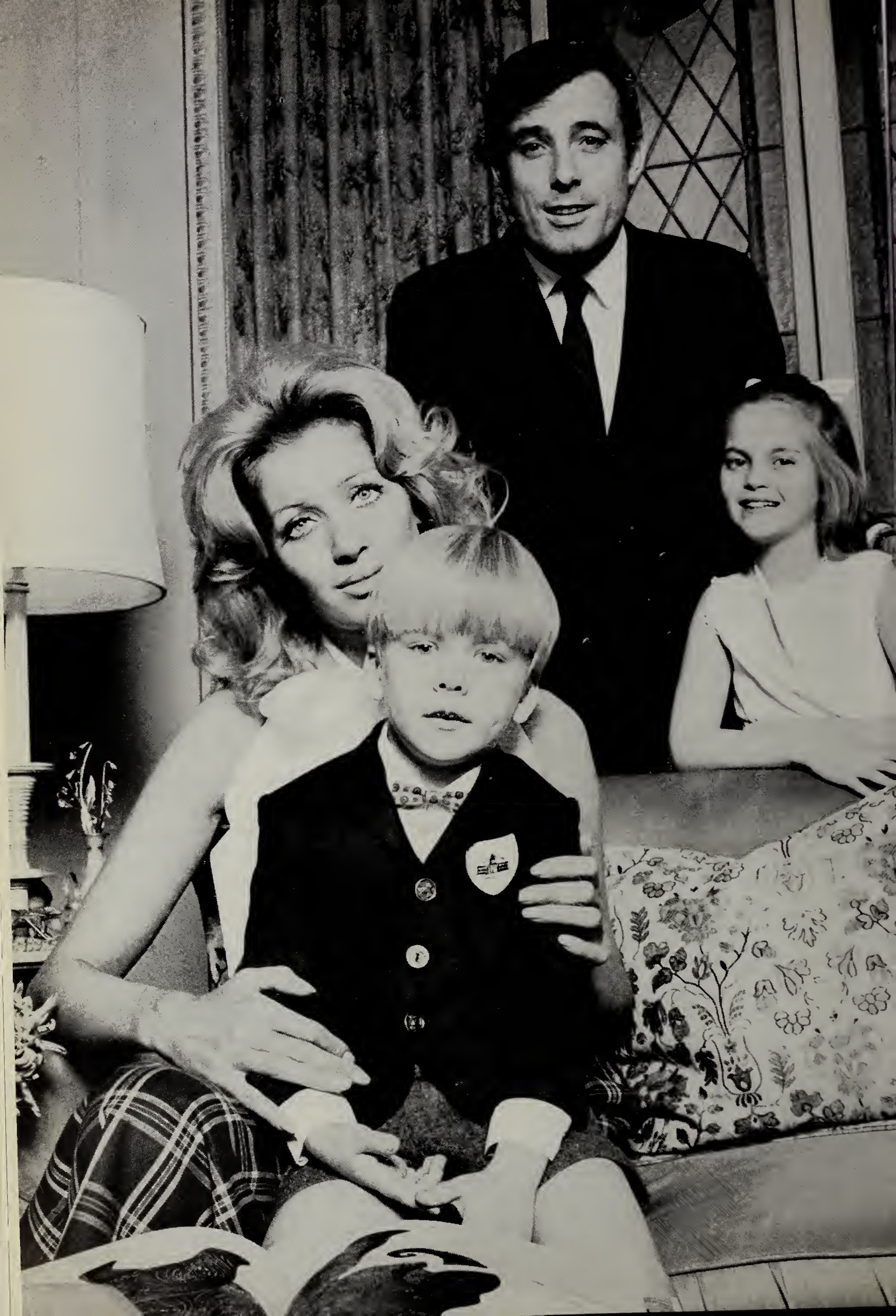
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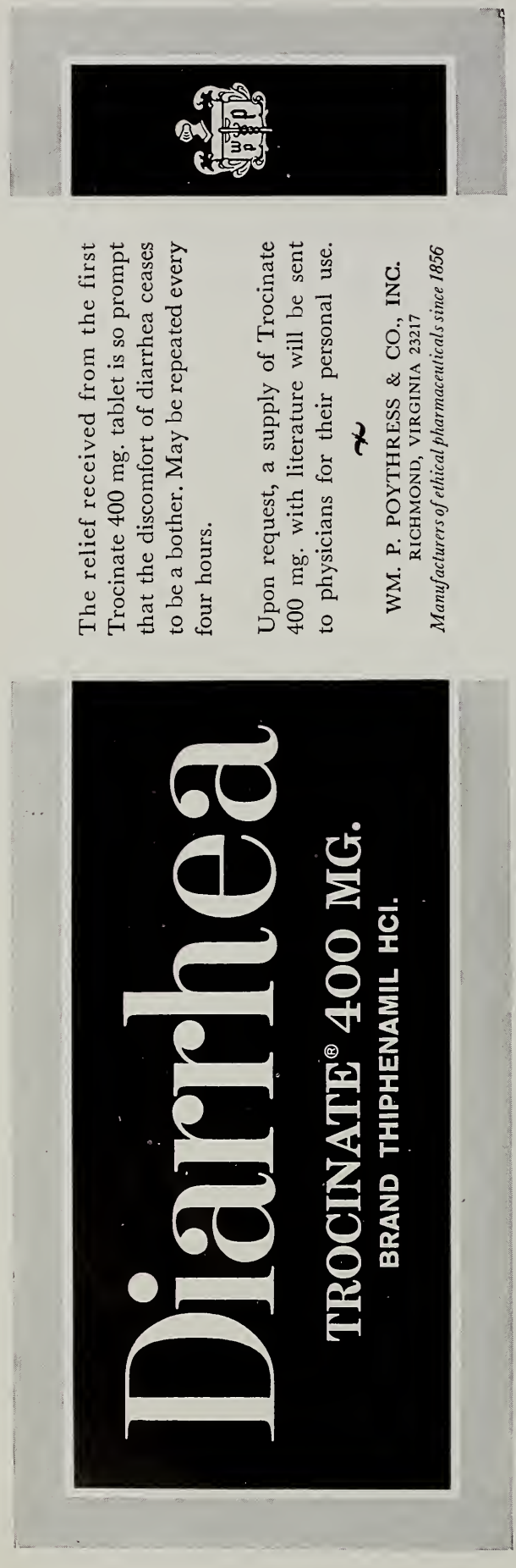
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Tobacco Industry Foots Heavy Research Tab

One of medical science's most intensive investigations gained additional scope today with pledges by six tobacco companies of an additional $8 million for the American Medical Association Education and Research Foundation's inquiry into the relationship of smoking and health.

The new pledges assure support of the research program through 1973. All of the funds will be allocated by the Foundation to independent scientists conducting research in their own laboratories.

Costs of administering the grants are paid by the American Medical Association and not from contributions.

The program began in June, 1964, shortly after the *Surgeon General's Report on Smoking and Health* was issued and the then-Surgeon General, Luther Terry, M.D., called for further research into the problem. Financial support came from the nation's physicians and an initial $10 million grant from the same tobacco companies.

Since then, 104 investigators or teams of investigators have been at work on the problem in 50 institutions in the United States and five foreign countries.

The companies aiding in support of the program are American Tobacco Co., Brown & Williamson Tobacco Corp., Liggett & Myers, Inc., Lorillard Corp., Philip Morris, Inc., and R. J. Reynolds Tobacco Co.

Both the original grants from the firms and the new pledges were made without restrictions, said Gerald D. Dorman, M.D., vice president of the Foundation. The only condition is that the money be used for research on tobacco and health, he said.

Contributed funds go directly to the Foundation, and grants are awarded by a six-member committee of scientists. The committee includes two scientists who served on the original advisory committee to the surgeon general.

"For many years," said Dr. Dorman, "the American Medical Association has repeatedly warned that smoking may be a health hazard; and this opinion has been supported by numerous other scientific organizations.

"But major questions about the problem remain unanswered by anyone—what is the exact chain of events inside the body when tobacco smoke is inhaled; which specific ills might be directly attributed to smoking; what are the elements in smoke which might create health hazards, and can these elements be minimized or eliminated?

"These are among the questions the Foundation is seeking to answer through basic research.

"This matter of the relationship of smoking and health has become an emotion-laden issue, and the Foundation feels it is very important and that all avenues of exploration be kept open. Unless you have the scientific facts and explanations, you can't make absolute judgments."

On June 19, a score of the independent scientist grantees from this nation and abroad reported their findings to date to the nation's scientific community during the AMA's Annual Convention in San Francisco. At the same time, more than 90 additional reports were published.

Early drafts of those reports suggest several important findings. These include:

—The most compelling evidence to date that dependence on smoking as a habit is psychological in origin, not physical.

—Clinical trials which indicate that frequency of smoking can be reduced by intravenous injections of nicotine; but that two drugs widely used to help smokers quit either have no effect or may actually increase smoking frequency.

—Further evidence supporting the long-held belief that patients with heart disease increase their risk of complications by smoking.

—Extensive studies of pairs of twins, some of them smokers and some non-smokers, which indicate that genetic and environmental factors other than smoking also may play an important part in the development of angina pectoris and bronchitis.

Subjects of other reports during the symposium will range from a clinical study of the effects of cigarette smoking in women to highly sophisticated physiological and biochemical studies of the effects of smoking on tissue.

"All of these investigations, some clinical and many quite basic in nature, add significantly to the body of scientific knowledge about the effects of smoking on health," Dr. Dorman said.

"But answers to the major questions—what are the exact, scientifically documented effects of smoking on the human and his tissues; what, if anything, can be done to make smoking more safe—are still inconclusive.

"This research must be continued in the years ahead if answers are to be found."

The tobacco companies, in pledging the additional $8 million grant, endorsed this goal.

Five of the firms, Brown & Williamson Tobacco Corp., Liggett & Myers, Inc., Lorillard Corp., Philip Morris, Inc., and R. J. Reynolds Tobacco Co., pledged their support over the five years from 1969 to 1973. The sixth firm, the American Tobacco Co., currently pledged its support for the year 1969.

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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION

JACKSON, MISSISSIPPI

July 1968

Dear Doctor:

With adjournment of record 1968 legislative session, state government will now move rapidly - although belatedly - in major health programs. Comprehensive health planning will be established directly under the Governor's office, and new agency will also be the prime mover in organizing Title XIX implementation.

> It's an open secret on Capitol Hill in Jackson that there will be a special session of the Legislature on health. Most feel, however, that massive spending on education and highways will stall final Title XIX action until last minute in 1969.

Four million Americans will feel less pain on their next trip to the dentist, but it has nothing to do with drills and novacaine. New painkiller is dental care insurance, fast growing as a financing mechanism. Insurance companies write contracts for 1.7 million, dental service corporations for 1.3 million, and labor unions for the remainder.

Mississippi Hospital Association, at recent convention, approved the concept of a uniform claim form for health insurance benefits. Action cited approval of state medical association in May, thus moving two largest components of health services - physicians and hospitals - into same orbit on handling third party benefit payments.

Seven out of 10 radiologists practicing in voluntary hospitals are billing patients directly, according to the American College of Radiology. This represents an increase of 10 per cent over 1967. An additional 10 per cent of radiologists are negotiating for separate billing with hospitals, but about 20 per cent say they will continue under hospital billing.

Part 1-B Medicare payments to Mississippi physicians maintain a brisk pace under Travelers Insurance administration. April totals were 18,500 claims paid, and May was about 17,700. Assignment rate continues to increase, too, going from 57 per cent in March to 62 per cent for April with May showing 66 per cent. Program is paying out about $750,000 per month to physicians.

Sincerely,

Rowland B. Kennedy
Executive Secretary

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DATELINE - MEDICAL AMERICA

Survey Shows No Overt Malnutrition In Mississippi

Jackson - A survey of 600 children in 17 Mississippi counties revealed no evidence of overt malnutrition, according to State Board of Health. Project was financed by U.S. Children's Bureau of HEW and sponsored by SBH, Children's Hospital Research Foundation, and University Medical Center. It followed 1967 Senate hearings charging "starvation" among some children in state. SBH says there are malnutrition problems in Mississippi, and that is reason for employing public health nutritionists, as is done in all states.

National Library Of Medicine Will Update MEDLARS

Bethesda, Md. - A contract for $2 million has been awarded to the Computer Sciences Corp. by the National Library of Medicine to redesign the Medical Literature Analysis and Retrieval System, popularly tagged MEDLARS. New system will be the "most sophisticated total data management system yet developed for today's third generation computers." NLM is custodian of world's largest medical literature collection.

Study Is Made Of West Virginia Draft Rejectees

Charleston, W. Va. - State Health Officer N. H. Dyer reports a study of 5,600 draft rejectees over past two years, emphasizing that one out of four failed because of health reasons. Chief problems were circulatory disease, eye conditions, and bone and motion impairment, in that order. Other rejectees fell in categories of apathy, irresponsibility, and fear of military service.

Title XIX Costs Exceed HEW Estimates

Washington - The federal share of Title XIX programs will hit $2.1 billion in fiscal 1968, a third more than the administration's estimate of $1.7 billion. The Congress has been asked to put up the extra $500 million. Program restrictions included in 1967 amendments may help contain mounting costs, especially withdrawal of all federal funds on Part 1-B buy-in. HEW believes that by 1971, federal share for Title XIX will be $3 billion. Cost factor may put economy pressures on states.

NIRMP Rounds Out Successful Decade

Evanston, Ill. - The Association of American Medical Colleges reports that for the 11th consecutive year, the National Intern and Resident Matching Program has successfully served 96 per cent of all U.S. medical graduates. Organized in 1958, NIRMP takes preferences from graduates and attempts to place new M.D.'s in training hospital of choice. There are, however, almost twice as many intern positions in hospitals than there are new M.D.'s.

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Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
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Alcohol-Cancer Study Is Begun at NYU

A long-suspected relationship between alcoholism and cancer of the head and neck will be the subject of a pilot study conducted by the Research Foundation of the State University of New York. The study will be financed by the Cancer Control Program, National Center for Chronic Disease Control, Public Health Service.

Dr. William L. Ross, chief, Cancer Control Program, said that under terms of the contract, the foundation will perform complete examinations of male and female alcoholics admitted to the Downstate Medical Center in Brooklyn. The object will be to determine to what extent protein deficiency, vitamin deficiency, liver disease and other factors associated with alcoholism stimulate the development of cancer and precancerous sores of the oral cavity, oropharynx, and larynx.

Each patient will be interviewed to obtain data concerning his drinking habits, smoking habits, education, income, employment, ethnic background, age, sex, and other factors, Dr. Ross stated.

Mouth and chest x-rays will be taken, all abnormalities of the head and neck area will be charted, and cyotologic smears taken from each abnormality. A biopsy will be performed on each lesion which is either clinically suspected to be cancer or which yields a positive or suspicious cytologic specimen. Patients with positive biopsies will receive treatment which is medically indicated.

Numerous blood chemistry determinations will be made. In addition, salivary specimens will be collected and examined for pH and sodium and potassium content, since these tend to be abnormal in alcoholics.

The contract calls for dividing the total alcoholic study group into various categories, and then matching them with non-alcoholic control groups on the basis of sex, age, and smoking history.

Directing the study will be Dr. Benjamin Kissin, chief of the alcoholism division of the Downstate Medical Center, State University of New York. The responsibility for overseeing the work on behalf of the Cancer Control Program has been entrusted to Dr. Richard L. Hayes, assistant to the program chief and a dental officer in Public Health Service Commissioned Corps.

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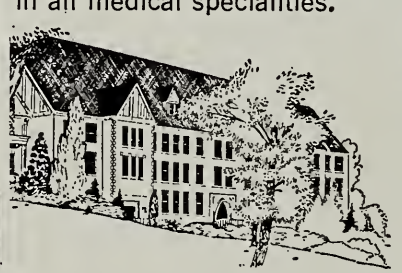
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Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

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ICS Slates Tokyo Surgical Congress

Surgeons and surgical specialists from virtually every country of the world will gather in Tokyo, beginning October 6, 1968, for the 16th Biennial International Congress sponsored by the International College of Surgeons.

Internationally renowned surgeons who are scheduled to address the convention include: Dr. Christian Barnard, Capetown, South Africa; Prof. Dr. H. Krayenbuhl and Dr. M. E. Muller, Switzerland; Prof. N. C. Louros, Greece; Dr. L. R. Dragstedt, University of Florida in Gainesville; Dr. Thomas E. Starzl, University of Colorado in Boulder; Doctors Edward L. Compere and Philip Thorek, Chicago; Dr. Yasumasa Aoyagi, Japan; Dr. Joseph H. Ogura, Washington University, St. Louis, Mo.; Dr. N. A. Puchkovskaya, U.S.S.R.; Prof. Dr. Fritz Holle, Germany; Prof. Dr. Tord Skoog, Sweden; and Dr. Richard W. Zollinger, Columbus, Ohio.

There will be simultaneous translations in French, English, German, Japanese and Spanish at the general assemblies.

Other key speakers from the U. S. are Doctors John S. Najarian, University of Minnesota, Minneapolis; Charles D. Kelman, New York, N. Y.; and Ward A. Soans, Kenmore, N. Y.

More than 200 other distinguished physicians from approximately 25 countries will present scientific papers and speeches during the six-day conference.

AOA Initiates Seven Seniors, Three Juniors at UMC

Seven recent graduates of the University of Mississippi School of Medicine have been selected for membership in Alpha Omega Alpha, honor medical society.

New initiates from the senior class are: Drs. Tom Morris and Bill Warfield of Clarksdale; Bobby Heath of Duck Hill; Jim Megehee of Pascagoula; and Dennis Murphree, Crawley Stubblefield and Wilford Patterson, all of Jackson.

Juniors tapped for membership include Thomas Windham of Jackson, Tate Thigpen of Picayune and Alan Mumm of Fairhope, Ala. Membership in Alpha Omega Alpha is based on scholarship, character and potential leadership.



JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
July 1968, Vol. IX, No. 7

SPECIAL ARTICLE

Medicine Tomorrow: The Anatomy of Change

TEMPLE AINSWORTH, M.D.
Jackson, Mississippi

THERE HAS BEEN a time within this century when doctors of medicine possessed about all the useful medical knowledge that existed, when they could learn any new knowledge about as quickly as it was published, and when they gave their patients the benefits of this modest art and science in that unhurried, almost casual day. And let it be quickly understood that there was much more art then than there was science.

At the turn of the century, the term "medical socioeconomics" had yet to be coined, and sometimes, within the state of Mississippi, the cost of medical care was reckoned in hams, turkeys, and canned goods. After all, medical expenditures had to be small, because there wasn't much to purchase. The mortality tables of 1900 clearly underscore this.

Now the science of medicine has thrust forward with such unbelievable momentum that some say there is no more art. The knowledge explosion has long since overwhelmed the individual practitioner, because there is too much, thankfully, for any one of us to know. Specialization has proliferated. The hospital as an institution of care has been revolutionized. And just about everybody is talking medical socioeconomics.

But the mortality tables of 1968 will proclaim that the changes have conferred almost a quarter of a century more life upon every American and have added life to years as well as years to life.

On this day in 1968 when the newborn baby has an excellent chance of living 80 years in a state of good health, there is a note of irony in recognizing that the financing of medical care and the manner in which it shall be delivered are major questions facing our profession today. But a genuine concern for the unimpeded flow of quality medical care in the context of today's high state of the science must take into account cost factors. It must also consider the organization and means of delivery, because the four pillars of any

The problems of medical care costs, financing of care, compensation methods for professional services, and a host of related factors are ironies in an age of medical progress, the 1967-68 president says in his address. He calls for realism in meeting these challenges, including the establishment of fee review committees in each component medical society.

The president urges support for a workable, realistic, and just means of purveying medical care to all, emphasizing that if our science is firmly positioned in the seventh decade of the 20th century, our philosophy ought also to be there with it.

President, Mississippi State Medical Association, 1967-68.
Read before the House of Delegates, 100th Annual Session, May 13-16, 1968.

free economy are production, finance, marketing, and distribution.

Medicine is a profession—not a business, but the financing of care has been made a business for us, whether we like it or not. The organization of care and the delivery system are subjects for deep concern by government and others apart from our professional circles.

We can, therefore, no more ignore these challenges than we can ignore the challenges of science. More than that, if we believe sincerely that a system of private practice and individual professional responsibility has merit, then we must speak with strong and authoritative voices in these discussions.

On two occasions this year, the President of the United States has spoken about the costs of medical care. He did so in his State of the Union Address. Later, in his economic message to the Congress, the President said that "last year, medical care prices rose 7 per cent, more than twice as fast as other prices. I shall propose new measures to slow down the spiraling cost of health care."

UPWARD SPIRAL

With no further reference to the President intended or inferred, it ought to be noted that the entire economy has been in an upward spiral. Of course, the costs of medical care have risen, but so have the costs of food, housing, automobiles, and all other goods and services. There are, on the other hand, the statistics of the matter, subject to all sorts of interpretation and arrangement, and on the other, some reasons why the economy of health care behaves as it does.

Americans spent more than $30 billion on the care of their health in 1966, and the annual rate of expenditures is rising at more than 5 per cent annually. A rise in the rate of expenditures does not always reflect a price increase, because when more individuals purchase more goods and services, the amount expended must increase.

We have a national economy which generates about $800 billion annually, and we call this the Gross National Product. After the tax bite, we Americans have over $500 billion left, and we call this our "disposable personal income." So in 1966, we spent 6 per cent of this remainder available to us on the care of our health. And we spent a third on housing and household operation, a fifth for food, and 12 per cent for transportation.

Even this doesn't tell the full story, because speaking at the National Conference on Medical Costs at Washington last year, the noted economist, Dr. Victor R. Fuchs, said that "if we measured all costs, the increase for medical care would not be as great as the GNP accounts indicate."

Our hospitals have experienced far greater cost increases than any other component in health care. The second round of wage increases under the minimum wage law largely accounts for the 1967 rise of 14 per cent in hospital costs to a record high of $56 a day nationally. Every indicator points to a 15 per cent rise this year. Most of the experts say hospital care costs will be $100 per day in 1970.

MEDICARE, XIX, POVERTY

A potent factor in accelerating health care expenditures has been government. Medicare is facing a $6 billion budget for 1968, and nobody really knows what the sum total of the Title XIX programs will cost. OEO's war on poverty may have suffered a cut at the hands of the Congress this year, but its health program received a 25 per cent increase.

Physicians' fees have risen, too, because physicians must provide for their professional premises, their supplies, their nurses and medical assistants, and they pay taxes, too. But the cost of physicians' services closely parallels the rise in the total cost of medical care and generally follows the pattern of all rising prices now.

The rise in physicians' fees was much slower coming than other general price increases, yet the portion of the health care dollar which he received has actually declined. In 1956, the doctor received 28 cents, but he got 27 cents in 1966. By contrast, the hospital received 25 cents in 1956 but got 31 cents in 1966.

These illustrations are part of a sincere and earnest effort to look at both sides of the cost coin, not to stand and offer defensive, subjective comment. Yes, these costs are rising, and yes, they are a matter of serious concern, and yes, every American must and somehow shall have the medical care he needs, and yes, we physicians do have a responsibility in seeking solutions to these problems.

SECURING CARE

There are basically four ways in which an individual may secure medical care: To purchase it from current resources, to contract with a third party to have it purchased for him in whole or part at some future time, to have society purchase it, usually through government, or to have medical care given to him.

For a variety of reasons, not necessarily cen-

tered on the physician, the fourth aspect, that of having care given, is impractical.

For the nation to purchase all of its health care out-of-pocket is also unrealistic, especially when the need for purchase may be a single event at a single point in time. So there remain the second and third aspects, those of insuring or prepaying and of having government make the purchase. The soundness, equity, and propriety of any method of medical care financing must be concerns of physicians as well as others, because physicians share in the responsibility for the success of methods which measure up to the needs of society.

And since a physician—and only a physician—properly can and ethically should place a price on his services, he has a further responsibility as to adequacy and proper use of financing devices.

In about two decades since the end of World War II , we have witnessed a rapid evolution in concepts of remunerating physicians under voluntary and governmental programs of care financing. We have progressed from the initial concept of indemnity through fixed fee to full service to negotiated fee. Then came the relative value index which progressed through a series of refinements.

USUAL AND CUSTOMARY

Now the sixth and most realistic development is compensation by the usual and customary fee. It is a range within which a majority of physicians in a given area make charges, and it is distinguished by being related to practice rather than formal agreement. The concept presupposes that the fee charged covers the professional services rendered, so to that exent, it embodies the best in the paid-in-full concept.

But usual and customary does not mean charging what the traffic will bear nor is a license to inflate fees beyond reason. The local medical community, meaning the component medical society, carries great responsibility in making this concept work.

For many years, component medical societies have offered the public a means through which to resolve dissatisfactions arising out of the physician-patient relationship in grievance committees. It would not, then, be a new experience for local societies to offer a means for dealing with fees outside their own established patterns.

It is equally important that the physician be represented, too, and that he has assurance of fair and equitable compensation.

I recommend strongly that each component medical society of our association establish a fee review committee and that able, knowledgeable members be appointed to serve on each committee. I urge that this important step be taken with the wholehearted support of every member of the association with the full understanding that they do not just seek remuneration but that proper remuneration is justly sought.

COMMITTEE AVAILABILITY

I further recommend that these committees be available to all elements concerned with the financing of medical care. The services of these committees should be given to matters submitted by patients, physicians, hospitals, prepayment and voluntary health insurance organizations, employers, and voluntary and governmental agencies.

The committees are not punitive and should have no disciplinary authorities.

I also recommend that each component medical society publicize the existence, availability, and function of its fee review committee through physicians' offices, liaison relationships with other organizations, society bulletins, and other media reaching both the profession and the public.

Let none think that this recommendation is an indictment of a single physician. Rather, let us understand that the gravity of the care cost picture, which is not ours alone to paint, leads us to this wise and timely step.

Let us understand that the clamor we hear may be the last knock on the door. If we make the system work, then it is less vulnerable to the attack of those who, for other reasons, would abolish it.

Recently, the Department of Health, Education, and Welfare published a report entitled "Promoting the Group Practice of Medicine." It speaks of group practice not as you and I have historically spoken but rather as a group of salaried physicians, bound to a central organization, whose duty it is to render care to those who subscribe to its services. The examples are Kaiser-Permanente, Ross-Loos, and the Health Insurance Plan of New York.

CLOSED PANEL GROUPS

Under this type of medical practice, which has also been identified as "closed panel," there are general practice, multi-specialty, hospital-based, branch, and medical school-based groups.

The report asks the questions of what can be done to control health service usage and how can state laws be strengthened in the interest of consumers of health care. It calls for enunciation of strong national health policy for prepaid group

practice, whether financed by government or private resources. It even suggests federal medical licensure.

This report is actually a recording of the proceedings of a conference sponsored at Washington on *how*—not *whether*—to promote group practice. The entire group practice movement, small but growing, is most assuredly another knock on the door.

There is a clamor and cry for increasing the role of government in group practice, of redesigning Medicare benefits for it, of rebuilding Title XIX around it, of even trying to force voluntary health insurance and prepayment into it.

But the existing delivery system of private practice which has brought superior health care services to America can and must continue. We want our physicians to remain independent and independently responsible. We want our hospitals to remain voluntary and locally controlled. We are willing to recognize the legitimate and proper use of public funds in providing care for those who cannot purchase it for themselves, as we have in Title XIX.

We recognize that times, the state of the art and science, the means of physician remuneration, and the financing of medical care do change. None of us is static in time, nor would we wish to be. We say only that we have recognized that it is no longer a matter of how the bill will be paid but of who will do the paying. But if we are to render the care, then we must logically possess a voice in the determination of the circumstances under which it will be rendered.

Let us move forward with the times with prudence, intelligence, and strength of purpose—not sacrificing a single principle we hold dear, asking only what is just and proper for the responsibilities we voluntarily bear. Let us understand the forces which motivate the changes and *not* take the role of the hide-bound opponent who has nothing to offer as a better alternative.

Let us be for a workable, realistic, and just means of purveying medical care to all, as we have always been but not necessarily as we have always done. Let us sit with knowledge and purpose in the councils of government, industry, and every appropriate segment of society, and let us speak frankly and sincerely but with reason and calm.

If our science is firmly positioned in the seventh decade of the 20th century, our philosophy ought also to be there with it. We cannot and will not turn back; we cannot and should not stand still; we can and will move forward uniquely, carrying the traditions of the past into a future of change. ★★★

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APTLY SECURE

The business executive returned home with an attitude of enthusiasm as he told his wife: "Today, we called in a psychologist and gave all of the employees an aptitude test. In fact, I took it myself."

"In that case," observed the less enthusiastic wife, "it's a good thing that you own the company."

Profile of Attainment—Measure of Need, Part I

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

THE NEED TO INTENSIFY and upgrade postgraduate medical education in the United States has been overwhelmingly documented at every level of medical organization and by almost every competent educational source. Government has also taken serious note of the challenge and opportunity in postgraduate medical education, so much so, in fact, that the Congress has acted affirmatively on various occasions to authorize and fund such programs. Not only is the Department of Health, Education, and Welfare and its medical branches, the National Institutes of Health and the United States Public Health Service, actively engaged in postgraduate medical education but the Department of Defense and even the Department of State, through the foreign aid program, are similarly involved.

Each of the 54 constituent state medical associations of the American Medical Association is expressing a continuing concern over the need for extension and improvement of postgraduate medical education, as is every medical specialty society in the nation. Despite extension and improvement of the traditional means of communicating postgraduate instruction to physicians and others in the health care field by journals, scientific assemblies, and existing postgraduate instructional programs, the problem seems to become increasingly acute.

The world's fund of scientific medical knowledge has escalated to staggering proportions in the last two decades. So rapid and so great has been the geometric increase of the data pool that conventional communications appear no longer adequate to move the knowledge from the initial source to those who eventually must possess and use it. That scientific communication is sadly lagging the accumulation of knowledge is a distressing fact.

The practicing physician finds himself in personal need of postgraduate guidance and assistance, because the pyramiding fund of new knowledge is greater than he can, of his own initiative, explore, sort, and absorb. He is keenly aware of his need in this connection, because he recognizes that the half-life of current medical knowledge is about 10 years, and the span is decreasing with every new discovery and advancement. It is also true that he does not have unlimited time to devote to postgraduate endeavors.

A major research project by the association on professional attainment by Mississippi physicians, postgraduate education desires and needs, assessment of existing postgraduate opportunities in the state, and a review of other studies was undertaken during the 1967-68 year. The study report was presented to and approved by the House of Delegates at the 100th Annual Session.

This is the first article of a series adapted from the study report, and it describes the scope of the study and the findings on the profile of professional attainment among Mississippi physicians. Subsequent articles will cover other aspects of the study.

Since the case for innovation, reorganization, direction, and increased effectiveness of postgraduate medical education is so clearly and forcefully supported by the overwhelming weight of all valid evidence, the Council on Medical Education of the Mississippi State Medical Association proposed this major study with a view toward:

—Assessing and defining the true dimensions of the problem as it exists among medical practitioners today in Mississippi.

Chairman, Council on Medical Education and member, Board of Trustees, Mississippi State Medical Association.

Adapted from the study report approved by the House of Delegates, 100th Annual Session, May 13-16, 1968.

—Measuring the degree of professional attainment of the practicing profession in Mississippi.

—Evaluating existing programs of postgraduate medical education as to adequacy and effectiveness.

—Examining in depth the individual desires, concepts of personal need, and instructional methodology preferences of Mississippi physicians as to postgraduate medical education.

—Determining the majority opinion or consensus as to postgraduate medical education from each specialty in Mississippi.

—And assuming the task of integrating these data of new information, broader perspective on the problem, and current definitions into a pertinent and timely interpretation to guide the development of a realistic, attainable postgraduate medical education program of maximum effectiveness for the medical profession of Mississippi.

During the course of four consultations with the state medical association's Board of Trustees, the council presented its views on this subject, a prospectus of this study, and requested and obtained approval and support of the Board to proceed.

From initial development to the publication of this report, the study extended over a period of 10 months from July 1967 through April 1968. The work of the study in the collection of a massive array of data, computer processing, and drafting was conducted exclusively by the state medical association's executive staff which has as one of its regular functions research and studies, especially in the field of medical socio-economics. A great portion of the data array was made available to the council and study task force from current records of the Mississippi State Medical Association. Additionally, the project was headquartered in the association's building, and the association's IBM computer was used to process the data. As a further contribution to the endeavor, the Board of Trustees made the services of the executives available for the project.

STUDY IS UNIQUE

The council hopes and believes that the study is unique in bringing together for the first time in our knowledge major expressions from authoritative institutions, the current voice of a state medical profession, an examination of the postgraduate attainment of that profession, a review of ongoing postgraduate medical programs, and a considered evaluation of these massive data toward the end of beginning a reach toward a worthy and vitally needed goal.

The measure of professional attainment among physicians can generally be little else than a comparison of closely related degrees of excellence. Any individual who attains the doctoral degree in a field of the life sciences has demonstrated an unusual capacity to learn, understand, and achieve. Thus, a measure of professional attainment among doctors of medicine begins upon a baseline far above the maximum achievement level of virtually all individuals of learning in educated society. And we must measure in millimeters where others would use yards, because we are viewing, for the most part, the professional attainment of the physician *after* he has earned the undifferentiated doctor of medicine degree.

IMPRESSIVE PROFILES

Many among those whose impressive professional profiles we are endeavoring to sketch with accuracy have devoted more years to postdoctoral study than anyone who has attained only the baccalaureate degree. To some extent, this describes the magnitude and delicacy of our tasks.

There are, however, differences in professional attainment among physicians which can and must be measured, and these take into account such variables as the undifferentiated medical degree, formal postgraduate training, practice experience, further academic pursuits, research endeavor, and a host of factors. And this is not to infer that the most competent, proficient, and highly informed physician could or would measure up to an ideal in all such areas. Indeed, if one were found to measure up in all such fields, he would be a professional curiosity and an academic freak.

A study of this nature also recognizes that high professional attainment is achieved in a variety of ways and is probably measurable by a number of equally reliable criteria. The sum total of any such serious assessment of all physicians in a geographically defined area, the state of Mississippi in the present study, should furnish a reliable index to:

—Extent of formal postgraduate training.

—Medical service potential expressed in terms of practice experience, sphere of professional interest, and training qualification.

—Minimum postgraduate training needs, based upon individual desires, personal assessments, and practical interpretation of these two points.

It is forcefully clear that nothing would be accomplished in the mere listing of physicians by training qualification alone. It would also be as undesirable as it would be unprofitable to make unfair or embarrassing comparisons with possible compromise of individual identity, and such

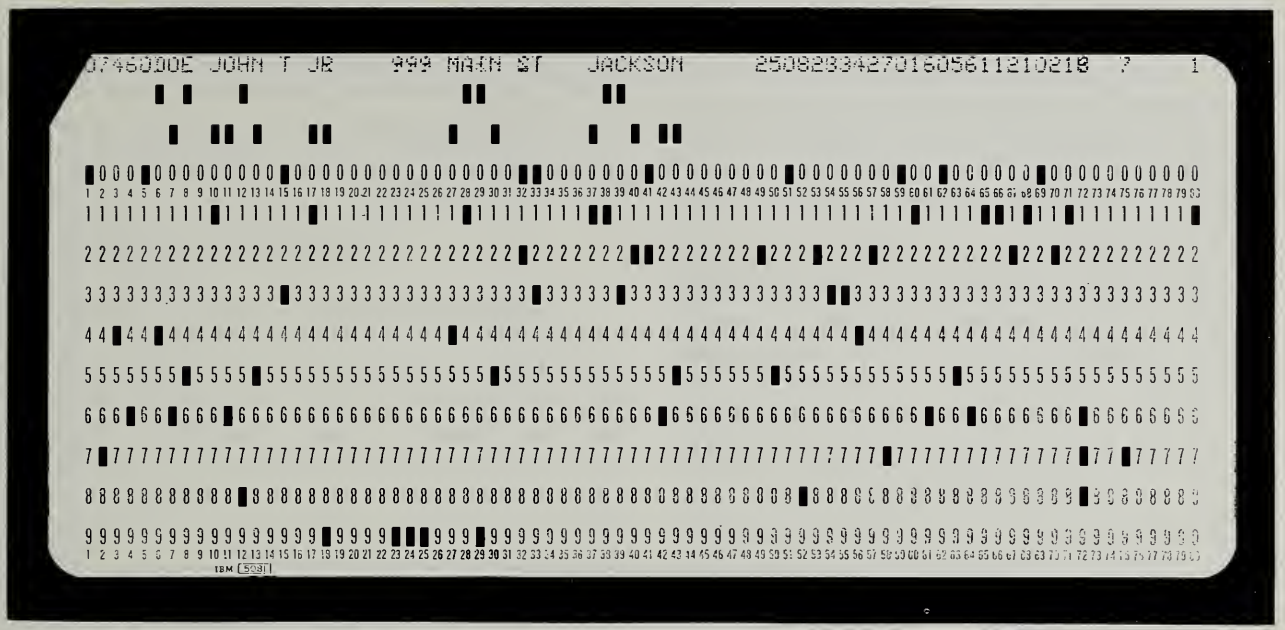


Figure 1. For each licensed physician in the state and nonlicensed federal medical officer, the association maintains complete records, both manually and by IBM punch card. An hypotheticated example of the latter is presented. This fictional physician, Dr. John T. Doe, Jr., has a serial number (cols 1-5) which permits the computer to find him by reading a five digit field. His name (cols 6-22), address (cols 23-36), and city of residence (cols 37-48) are shown. The ZIP code is omitted in these decks, being used in addressing and check-writing decks. He is a resident of Hinds County (cols 49-50), and he was born Aug. 23, 1934 (cols 51-56).

Dr. Doe was graduated from the University of Mississippi School of Medicine (cols 57-60) in 1960 (cols 61-62). He received one year of internship and five years of residency training (col 63). He was licensed to practice in 1961 (cols 64-65), and he is a general surgeon (cols 66-67) who is certified by the American Board of Surgery (col 68). He is a member of the Central Medical Society (cols 69-70), and his degree of membership is active (col 71). He was elected to membership by his society in 1966 (col 72), and the punches below the 6 digit indicate that he was a member in 1967 and has renewed his membership in 1968. Column 75 tells the computer that he attended the 1967 annual session of the association. Columns 76-97 are reserved for miscellaneous information which may be needed at some future time, and column 80 indicates to the computer which deck it is reading. An infinite variety of information may be obtained from this flexible data storage system.

would be at best a measure of achievement by individuals and not a professional profile.

The Membership Department of the Mississippi State Medical Association maintains detailed and current records on all licensed physicians. Each has a permanent file from which personal biographical data (excluding race, marital status, and religious preference) and professional attainment data are extracted and summarized on manual decks for individual reference and on IBM cards for data storage and processing. Information on physicians is periodically updated, usually by mail questionnaire to the physician himself and is also drawn from other sources, such as medical licensure records or academic institutions. Use was made of the IBM biographical and professional data in this study, and the manner in which the data are stored and retrieved is illustrated in Figure 1.

The data pool utilized from these valuable and existing records was made up of 1,604 physicians, some 172 records on interns and residents of the total of 1,776, being immediately discarded as distorting the study:

Nonsurgical disciplines	1,108
Surgical disciplines	412
Miscellaneous classifications	84

The latter classification was subsequently discarded because it contains data on 73 retired physicians and 11 in the military service. Every effort was exercised to avoid distortion of the profile.

A data processing program was designed to retrieve information as to discipline or classification, formal postgraduate training in internship and residency programs in years, and whether the individual physician has sought and received certification by an American board. Table 1 lists 13 nonsurgical classifications. This is not to ignore

any subspecialty which does not appear in the table; this simply reflects that the absence of such a designation means that no physician in Mississippi has so classified himself and reported this to the association.

As with any records system, there are some few incomplete items. Among the 1,108 physicians classified for the purposes of the study in nonsurgical disciplines, there are no data on formal postgraduate training for 76, a loss of 6.86 per cent in this portion of the universe. Among the 412 physicians classified in surgical disciplines, there are no formal postgraduate training data on nine, a loss of 2.18 per cent. There can, however, be little argument over the validity of bodies of data which are, respectively, 93.14 and 97.82 per cent complete. Moreover, additional caution was exercised in arriving at conclusions by actually omitting the "training unknown" classifications in some instances.

NONSURGICAL CLASSIFICATIONS

Only two of the 13 classifications in Table 1 show more than 100 physicians. These are general practice and internal medicine. While it is fully appreciated that general practitioners perform surgery, the discipline was classified for purposes of the study, inasmuch as the formal core content of the general practice residency leading to certification by a proposed American Board of Family Practice has not yet been fully agreed upon by all interested parties, as a nonsurgical discipline.

Nine classifications appear in Table 3 which displays data on the surgical disciplines. As before, omission of any subspecialty merely indicates that no Mississippi physician so classifies himself and has reported this classification. Of the 412 physicians comprising this general category, only one discipline, that of general surgery, exceeds 100 in number.

FORMAL PG TRAINING

In examining the data presented in Tables 1 and 3, it should be noted that the extent of formal postgraduate residency training is shown in years for each discipline. Those training more than five years are listed in a single category, designated +5. A careful review of the records shows that most such physicians received six years of postdoctoral training, so computations were made on the uniform basis of six years. A very few received more than six years' training and it is notable that four physicians in the data universe received nine years. These data were processed by actual years of training and by using the uniform constant of six years, and it was observed that the variation was less than 0.004 per cent. Therefore, the decision was made to use six years as the uniform constant, and the data are accordingly not distorted.

Thirteen classifications appear in the records of the Mississippi State Medical Association which have been classified as nonsurgical. These are pediatrics, psychiatry and neurology (there being so few neurologists in Mississippi as to make a separate listing meaningless), dermatology, internal medicine, pathology, anesthesiology, preventive medicine (public health), general practice, pulmonary diseases, allergy, cardiology, hematology, and radiology. Where a specialty stands out distinctly as a field of medical endeavor apart

TABLE 1

POSTGRADUATE TRAINING PROFILE, NONSURGICAL SPECIALTIES

Classification	*No. in Class*	*Yrs. Formal Training Beyond 1 Yr. Internship*								*Board Cert.*	*Not Cert.*
		0	1	2	3	4	5	+5	UNK		
Pediatrics	74	6	7	40	15	3	0	1	2	44	30
Psychiatry and Neurology	43	8	4	4	17	6	2	2	0	10	33
Dermatology	14	1	1	0	8	1	1	2	0	7	7
Internal Medicine	110	6	7	23	42	17	7	5	3	37	73
Pathology	40	2	4	4	11	12	4	1	2	31	9
Anesthesiology	32	0	0	24	4	2	1	0	1	9	23
Preventive Medicine	32	18	9	2	1	2	0	0	0	7	25
General Practice	697	414	137	42	21	8	5	4	66	Not applicable	
Pulmonary Diseases	4	1	1	0	1	0	0	1	0	0	4
Allergy	8	4	0	0	2	1	0	0	1	1	7
Cardiology	4	1	0	1	3	0	0	0	0	2	2
Hematology	1	0	0	0	1	0	0	0	0	1	0
Radiology	49	3	4	3	31	4	1	2	1	33	16

TABLE 2

COMPOSITE PG PROFILE, NONSURGICAL SPECIALTIES

*Classification**	*No. in Class*	*Yrs. Formal Training Beyond 1 Yr. Internship* MEAN(YRS.)	MEDIAN(YRS.)	MODE(YRS.)	*Per Cent Certified*
Pediatrics	66	2.37	2	2	59
Psychiatry and Neurology	35	3.11	3	3	23
Dermatology	13	3.54	3	3	50
Internal Medicine	101	3.09	3	3	34
Pathology	36	3.31	3	4	78
Anesthesiology	31	2.35	2	2	28
Preventive Medicine	14	1.71	1	1	22
General Practice	217	1.68	1	1	Not applicable
Pulmonary Diseases	3	3.33	3	—	0
Allergy	3	3.33	3	2	0
Cardiology	3	3.66	3	3	50
Hematology	1	3.00	3	3	100
Radiology	45	3.02	3	3	67

* Those with no formal training beyond one year of internship and those whose formal training is unknown are omitted from this profile. Physicians with more than five years training are computed uniformly as having six years.

from easy inclusion with a general discipline, and the example is hematology, this was separately listed.

In study of Table 1, it is observed that 464 of 1,108 physicians in nonsurgical disciplines in Mississippi have only one year of internship as formal postgraduate training. This is by no means an indictment of insufficient postgraduate training. For many in their day, age being a factor which was not brought into the study, this represented postgraduate training which was in full conformance with the demands and capabilities of the times. Some few of these physicians are certified by their respective American boards, reflecting personalized endeavor at self-improvement in the quest of further training and professional preparation. Since general practitioners are currently engaged in establishing training programs which would lead to certification by a proposed new American board, it appears pertinent to note that their exclusion from these data leaves 50 specialists who received only the one year internship. It is also notable that four out of 10 general practitioners have received one to five years of formal postgraduate training.

BOARD DIPLOMATES

On the reasonable basis of excluding general practice from the 13 classifications for certification comparisons, it is encouraging to note that 45.98 per cent of such Mississippi physicians have been certified by their respective American boards. It is not and will not be the purpose or intent of this study to make a case for board certification, but in the context of the goal of the study, it is appropriate to note that at some point in time, nearly half of the nonsurgical specialists have submitted themselves to examination and have been found worthy of board certification.

AAGP APPLAUDED

In the same context, the Council on Medical Education applauds the American Academy of General Practice for its vigorous posture on postgraduate medical education under which a member may suffer pain of expulsion for failing to meet minimums in such pursuits. Moreover, the Academy has been an effective leader in seeking new heights of professional attainment for the family physician through organization and approval of general practice residencies and the authorization of a new American board to which general practitioners meeting rigorous criteria may apply for certification.

Table 2 presents a composite postgraduate training profile for the nonsurgical specialties. It is fully realized that there is no average physician, that training means more to some than to others, and that dangers lurk in portraying any medical discipline wherein its followers are cut to a uniform size. But there must be a measure, and any homogeneous group can be viewed through the same lens. As the footnote explains, those among the 13 nonsurgical disciplines with one year of internship only or whose formal postgraduate training is unknown were eliminated for the purpose of constructing this final profile. Thus, the 1,108 in this part of the data universe were reduced to 568 by excluding 464 with one year internship only and 76 whose formal postgraduate

training was unknown.

Each classification was then measured in years of formal training after internship in three ways: by the mean, the median, and the mode. Few of our learned readers require a reminder of these statistical methods:

Mean. Most popularly known as the "average," the mean is an arithmetic midpoint among unequal quantities derived by dividing the sum of the quantities by the number of quantities. It is quite useful when the data in a series fall closely together, but when they are spread over a span of values so as to be substantially unequal, the mean may distort the data presentation.

Median. The median is simply that point in a statistical series where half of the data are to one side and half are to the other. To the extent that the median divides the data into useful and understandably comparable groups, it is helpful.

Mode. The mode, literally "the fashion" from the French *la mode,* is simply that quantity which occurs most often in a statistical series. It quickly identifies the "most usual" quantity for easy data comparison.

HIGH TRAINING LEVEL

Among the nonsurgical specialties represented by 35 or more physicians, again excluding general practice, four out of the five disciplines, pediatrics, psychiatry and neurology, internal medicine, pathology, and radiology, show a mean postgraduate training in formal residencies of more than three years. Pediatrics shows a mean training time of 2.27 years, but the specialty may boast that six out of 10 Mississippi pediatricians who underwent formal residency training are board certified. Of the five groups, pathologists have received most formal postgraduate training, 3.31 years by the mean and four years in modal occurrence, and have the highest frequency of board certification, 78 per cent.

It is notable that the largest group, the internists, regardless of age and time of training, exceed current residency requirements. Those in preventive medicine have the least formal training with a mean postgraduate time of 1.71 years beyond the internship. Radiologists are uniformly well trained with 3.02 years and a certification rate of 67 per cent.

THREE YEAR MODE

Each of the remaining seven disciplines, with the exception of preventive medicine as noted and anesthesiology, shows formal training in excess of three years. The training of anesthesiologists fully conforms with requirements of the American Medical Association and the American Society of Anesthesiologists. Dermatologists and cardiologists show the most formal postgraduate training, 3.54 years and 3.66 years respectively measured by the mean, of any of the 13 disciplines.

Six out of 10 general practitioners, 414 or 59.39 per cent, received one year of internship as the extent of formal postgraduate training. Of the remaining 217 in this discipline, there is a mean postgraduate training period beyond the internship of 1.68 years, but 80 general practitioners report formal postgraduate training of two to more than five years.

The records of the state medical association list nine surgical specialties in which there are 412 physicians. These are EENT, orthopaedic surgery, urology, obstetrics and gynecology, ophthalmology, otolaryngology, general surgery, plastic surgery, and neurological surgery. The classification EENT is taken directly from physicians' biographical data forms of those who do both ophthalmology and otolaryngology. It is un-

TABLE 3

POSTGRADUATE TRAINING PROFILE, SURGICAL SPECIALTIES

Classification	*No. in Class*	*Yrs. Formal Training Beyond 1 Yr. Internship*								*Board Cert.*	*Not Cert.*
		0	1	2	3	4	5	+5	UNK		
EENT	16	1	2	2	5	3	2	0	1	1	15
Orthopaedic Surgery	38	2	2	3	8	16	2	3	2	17	21
Urology	24	2	1	2	5	10	2	2	0	9	15
Ob-Gyn	88	6	8	14	42	13	1	2	2	32	56
Ophthalmology	32	0	5	3	12	8	0	2	2	20	12
Otolaryngology	31	4	6	8	8	4	0	0	1	25	6
General Surgery	170	16	16	12	25	59	23	19	0	74	96
Plastic Surgery	4	0	0	0	0	2	1	0	1	2	2
Neurological Surgery	9	1	0	0	1	2	3	2	0	6	3

TABLE 4

COMPOSITE PG PROFILE, SURGICAL SPECIALTIES

*Classification**	*No. in Class*	*Yrs. Formal Training Beyond 1 Yr. Internship* MEAN(YRS.)	MEDIAN(YRS.)	MODE(YRS.)	*Per Cent Certified*
EENT	14	3.07	3	3	6
Orthopaedic Surgery	34	3.65	4	4	45
Urology	22	3.73	4	4	38
Ob-Gyn	80	2.89	3	3	36
Ophthalmology	30	3.03	3	3	63
Otolaryngology	26	2.38	2	3	81
General Surgery	154	3.77	4	4	44
Plastic Surgery	3	4.33	4	4	50
Neurological Surgery	8	4.75	5	5	67

* Those with no formal training beyond one year of internship and those whose formal training is unknown are omitted from this profile. Physicians with more than five years training are computed uniformly as having six years.

derstood that many in this group received postgraduate training in both of the specialty disciplines.

Table 3 displays data on each discipline, showing formal postgraduate training by years. Only 32 of the 412 physicians in this general classification received no formal postgraduate training beyond the one year of internship, 7.77 per cent, and as previously noted, the extent of formal training is unknown for nine, 2.18 per cent.

The composite postgraduate training profile, consisting of 371 physicians which excludes those with no residency training and those whose training is unknown, is presented in Table 4. Five of the nine disciplines show a high degree of formal postgraduate training with median and modal occurrences of four years, except for neurological surgery, which shows five years, the highest degree of training found in this study. The other disciplines are orthopaedic surgery, urology, general surgery, and plastic surgery.

None of the five disciplines shows a mean residency time of less than 3.65 years, for orthopaedic surgeons. The two highs are for plastic surgeons, a mean of 4.33 years, and neurological surgeons, a mean of 4.75 years.

SURGERY LARGEST

The largest single classification among the surgical specialties is general surgery with 154 physicians who have received at least one year of formal postgraduate training after internship. The discipline shows a mean training period of 3.77 years, but the median and modal time are each four years. Among this group, 44 per cent are diplomates of their American board.

The rate of certification ranges from 38 per cent for urologists up to 67 per cent for neurological surgeons.

In the remaining four surgical disciplines, EENT, obstetrics and gynecology, ophthalmology, and otolaryngology, two show mean postgraduate training of more than three years with 3.07 for EENT and 3.03 for ophthalmology. Interestingly, these two disciplines, although related closely, reflect extremes in the rate of certification, EENT being 6 per cent and ophthalmology being 63 per cent. The former probably results from the old combination residencies which would ordinarily not satisfy current American board requirements.

OB-GYN SECOND

The second largest surgical discipline, obstetrics and gynecology, shows a mean formal postgraduate training time of 2.89 years but median and modal times of three years. A third of these specialists are certified. While the mean training time of otolaryngologists is 2.38 years, this discipline carries the highest certification rate found, 81 per cent.

Of the entire group of 412 in the surgical specialties, 186 or 45.14 per cent are diplomates of their respective American boards. Excluding those with no formal residency training, there is no discipline in the entire classification with a mode of less than three years of postgraduate work, and more than half of the disciplines have a modal rate of four years.

The unique profile of professional attainment is not aimed so much at the discovery and identification of deficits as it is for amplification of capabilities and assurance of continuing quality medical services. For those who may wish to measure a specialty against an ideal, as is the accepted practice in the study of morbidity and mortality

patterns, it is suggested that the profile of attainment be examined in the light of appropriate American board training requirements. This assumes, obviously that the training has been received in an approved residency program.

Finally, it is acknowledged that inclusion of age, years of practice, and certain other factors may have been additionally helpful in assessing postgraduate medical education needs, but there is a thin line between this area and that of health manpower, entirely another field which beckons investigation and study. Factors of time, funds, and staff posed problems in extending the present study beyond its already ambitious boundaries. This is another challenge for another day. ★★★

2500 N. State St. (39216)

This study was assisted in part by the Regional Medical Program of the University Medical Center, Jackson.

SWORD OF SIR LOIN

The gentleman dining in the plush restaurant was served a sirloin steak. The first try at cutting it was unsuccessful, because the meat was tough. On the second attempt, his knife broke.

Beckoning the captain, the irate diner held up the broken knife and said, "Just look at that!"

"I know, sir," was the quiet reply. "You just can't buy that good steel in knives any more."

The Mississippi Program of Chemoprophylaxis for the Prevention of Tuberculosis

LEE R. REID, M.D.
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In October and November 1967 the Division of Tuberculosis Control, Mississippi State Board of Health, launched a comprehensive chemoprophylaxis program. Arrangements have been made to furnish the isoniazid free of charge to individuals who cannot pay for the drug. The author discusses in general the usefulness of isoniazid prophylactically in tuberculosis and considers the Mississippi program in detail.

FOR THE LAST FEW YEARS much attention has been directed toward the use of isoniazid, prophylactically, in tuberculosis. Of particular interest has been the work of the United States Public Health Service in a series of studies done to determine the usefulness of this drug as a prophylactic measure in regard to the following situations:

1. Prevention of occurrence of clinical tuberculosis among those who have had the primary form of the disease.
2. Prevention of the reactivation of clinically and roentgenographically "healed" disease in known cases of tuberculosis.
3. Prevention of the development of serious forms of the disease (miliary and meningeal) among infected children.

Their cases, a grand total of about 70,000 of them, were divided into two groups. Half the total number were given I.N.H. in doses of 300 mg. per day for one year. (Children received 10 mg. per kilogram up to 300 mg. per day.) The other half received identical but placebo tablets. Their interest was centered not so much on what percentage of cases under certain conditions developed tuberculosis but of those who did develop the disease, how many had received I.N.H. prophylactically as compared to those who had not.

They were successful in following up around 99 per cent of the total 70,000 cases. In round numbers, out of the 70,000 tested and followed, 700 contracted tuberculosis in one form or another. Out of this number only 200 were cases that had received I.N.H. compared to 500 who were not protected by the drug.

Several factors are of special interest. First, that by taking I.N.H. for one year, apparently there was protection from tuberculosis in over 60 per cent of the cases. It must be pointed out at the same time that in spite of taking I.N.H., 200 cases developed tuberculosis. This indicates that chemoprophylaxis with I.N.H. is by no means a complete success. Since it is certain that some of the cases did not actually take the drug as directed, this would indicate that the number of failures would in reality be considerably lower than is shown here.

The most striking results were in the protection of children from the miliary and meningeal forms of the disease. Perhaps no manifestations of tuberculosis are as dangerous as these two types. In 1,000 children who showed positive tuberculins and other evidence of primary tuberculosis, 34 cases of miliary and meningeal appeared. Of these 34, only 4 that had been protected by I.N.H. developed disease which is a very impressive result.

In cases with x-ray evidence of so-called "healed" disease, out of every 1,000 observed, 86

From the Division of Tuberculosis Control, Mississippi State Board of Health.

reactivated their disease during the period of observation. Of these 86 cases, only 26 were among those receiving the I.N.H. and 60 among those unprotected by the drug. Out of 1,000 household contacts between the ages of 15 and 20 years, 35 cases of tuberculosis developed. Eleven were among the ones receiving I.N.H. and 24 were among those on the placebo. In household contacts, overall, 66 new active cases of tuberculosis appeared per 1,000. Of these 66 only 19 had received chemoprophylaxis; 47 had not.

All experts on tuberculosis feel that these figures are of major significance and the use of chemoprophylaxis is becoming an important part of practically all programs of tuberculosis control.

It is known that in the general public 25 new cases of tuberculosis are found yearly for every 100,000 of the population. Among those who have a positive P.P.D., around 100 new active cases are found. In other words, the presence of a positive tuberculin reaction increased a person's chances of developing clinical tuberculosis around 75 per cent. It is felt that by chemoprophylaxis we can reduce this figure to much nearer the level of the general population. This in itself can justify the effort and expense of chemoprophylaxis.

The Mississippi State Board of Health and its affiliated county health departments were greatly interested when the National Tuberculosis and Respiratory Disease Association Committee for the Guidance of the Tuberculosis Program established an Ad Hoc Committee on chemoprophylaxis with representation from the American Thoracic Society Committee on Therapy, the National Thoracic Society Committee on Respiratory Diseases in Children, the United States Public Health Service, and the National Tuberculosis and Respiratory Disease Association Committee for the Guidance of the Tuberculosis Program.

REPORT PUBLISHED

After much study, the report of this committee appeared in the *American Review of Respiratory Disease,* Vol. 96, Number 3, Sept. 1967. Soon afterwards the report became available in pamphlet form. These can now be obtained through the Division of Tuberculosis Control, Mississippi State Board of Health, P. O. Box 1700, Jackson, Mississippi 39205, or from the Mississippi Tuberculosis Association, 353 North Mart Plaza, Jackson, Mississippi 39205.

In October and November 1967 the Division of Tuberculosis Control, Mississippi State Board of Health, launched a comprehensive chemoprophylaxis program under the name of "Chemoprophylaxis Program '68."

All of the suggestions made in the Ad Hoc Committee report were adopted. Some were changed slightly to fit more closely the needs and capabilities of the county health departments in Mississippi. The Division of Tuberculosis Control for several years has had a program of prophylaxis in effect in regard to household contacts with active cases of tuberculosis. Chemoprophylaxis Program '68 has supplemented and broadened this.

PROGRAM CATEGORIES

The nine categories covered are as follows:

1. Contacts. All household contacts are put on chemotherapy for one year following termination of contact with an active case. (The case is indexed when there is negative sputum and no evidence of change by x-ray for 6 months, or when the patient has been sent to the Sanatorium and has returned with an inactive status or when the sputum is negative for 6 months.) These contacts should have regular, repeated tuberculin tests and an x-ray at six-month intervals for two years following termination of the chemoprophylaxis.

2. Positive tuberculin (Heaf grade 2, 3, 4, or Mantoux 5 mm. or over) below age of 20 years.

3. Tuberculin converters.

4. Ex-patient with inadequate or no previous chemotherapy.

5. X-ray evidence suggesting healed disease with positive tuberculin (Heaf grade 2, 3, 4, or Mantoux 5 mm. or over) and no previous treatment, prophylactic or other.

6. Pregnancy (Heaf grade 2, 3, 4, or Mantoux 5 mm. and over). (Chemotherapy should be given during the last trimester and continued for one year.)

7. Special clinical situations with positive tuberculin (Heaf 2, 3, 4, or Mantoux 5 mm. or over). a. corticosteroid treatment, b. gastrectomy, c. leukemia or Hodgkin's disease, d. unstable severe diabetes.

8. Measles or whooping cough in children with positive tuberculin (Heaf grade 2, 3, 4, or Mantoux 5 mm. or over). a. Previously given treatment, prophylactic or therapeutic (give chemoprophylaxis for two months). b. No previous chemotherapy (give chemoprophylaxis for one year).

9. Positive tuberculin (Heaf grade 3, 4, or Mantoux 10 mm. or over).

The county health departments are not limited by these nine categories and are authorized to put anyone at even slight risk under chemoprophylaxis if desirable.

When candidates for chemoprophylaxis are discovered by the county health departments, the need for treatment is explained to them individually, and they are instructed to contact their family physician and acquaint him with the situation. In case there is any objection on the part of the physician, the matter is recorded and the case promptly closed by the county health department.

Arrangements have been made, at least, for the present, to furnish the I.N.H. free of charge to those individuals stating that they could not pay for the drug.

It should be pointed out that isonicotinic acid hydrazede (I.N.H. or isoniazid) is unique in its power to control tuberculosis while at the same time being almost completely nontoxic. There are actually no absolute contraindications. The drug probably should not be used as a prophylactic measure in epileptics. There is also some need for caution in its use in severe kidney disease. In patients in whom central nervous system stimulation is to be avoided, I.N.H. should probably not be used in a prophylactic type of treatment.

Reactions to the drug are extremely rare. When they occur, the most annoying is slight peripheral neuritis. This can be prevented, in a high percentage, by the simultaneous use of Vit. B6 (Pyridoxine). In extremely rare instances, an optic neuritis has been reported so the drug should be discontinued on complaint of visual disturbances and the patient referred for ophthalmological examination before resuming the drug. Prostatic obstructive syndrome has been reported.

Hundreds of thousands of people have been or are now being treated both therapeutically and prophylactically with I.N.H. without the slightest difficulty.

Several general findings are important:

1. Chemoprophylaxis does not result in the organisms becoming resistant to the drug.

2. The length of protection conferred by a year of I.N.H. is not known exactly but is felt to be many years, if not indefinitely.

3. The use of "booster" administration of another year of the drug may prove to be necessary if experience shows that protection is not indefinite.

4. Complete protection by use of I.N.H. in chemoprophylaxis has not been realized, but an overall protection of over 60 per cent is very well worth the efforts expended.

The Division of Tuberculosis Control of the Mississippi State Board of Health considers this program the most important step towards tuberculosis control taken in Mississippi since the present system of home treatment was set up about 15 years ago. We request the cooperation of all private physicians and are anxious to be of any assistance possible in explaining the program to them. ★★★

State Board of Health (39205)

INFERIOR DECORATING

Not all cost components in the medical care picture accrue to the physician. Consider, for example, the patient who paid his psychiatrist for curing him of an inferiority complex and was later fined $25 for talking back to the traffic policeman.

Constitution and By-Laws of the Mississippi State Medical Association

CONSTITUTION

Preamble

That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this Association. Among us, membership is a privilege, earned by professional qualification, personal honor, and selfless service; it is not a right vested superficially nor by statutory licensure. Truth shall be our quest; diligence, our staff; and service, our purpose.

Article I
NAME OF THE ASSOCIATION

The name and title of this Association shall be the Mississippi State Medical Association.

Article II
PURPOSE OF ORGANIZATION

The purpose of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Mississippi and to unite with similar associations in other states to form the American Medical Association, with a view toward the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws, to the promotion of friendly intercourse among the physicians and to guarding and fostering of their opinion in regard to the great problems of medicine, so that the profession shall become more honorable and capable within itself, and more useful to the public in the prevention and care of disease, and in the prolonging of and adding comfort to life.

The purpose of this Association shall be to promote scientific medical research and practice and it shall be a non-profit organization.

Article III
COMPONENT SOCIETIES

Component Societies shall consist of those societies which hold charters from the Association.

Article IV
MEMBERSHIP

Section 1. Members of the Mississippi State Medical Association. Members shall be active, associate, or emeritus, acording to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate shall be construed as active in connection with the rights and privileges accruing therefrom.

Section 2. Guests. Any physician not a resident of the state may become a guest during any annual session upon invitation of a member of the Association, and shall be accorded the privilege of participating in all the scientific work of that session.

Article V
SESSIONS AND MEETINGS

Section 1. The Association shall hold an annual session during which there shall be held daily not less than two general meetings, which shall be open to all registered members and guests.

Section 2. The time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix, or change, either the time or the place, or both of the annual session.

Article VI
GENERAL OFFICERS

Section 1. The general officers of this Association shall be a President, President-elect, three Vice-Presidents, one from each Supreme Court District, Secretary-Treasurer, Speaker, Vice Speaker, and Editor.

Section 2. The President, President-elect, and Vice-Presidents shall hold terms of one year. The Secretary-Treasurer, Speaker, Vice Speaker and Editor shall be elected for terms of three years.

Section 3. The officers of this Association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend two-thirds of the past two and current annual sessions and who has not been a member for the past two years.

Section 4. In addition to these general officers, there shall be an Executive Secretary who need not be a physician or member of the Association. He shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. His compensation and expenses for duties performed shall be fixed by the Board of Trustees and confirmed by the House of Delegates.

Article VII
EXECUTIVE OR CENTRAL OFFICES

The Executive Secretary shall maintain in the city of Jackson suitable offices for the discharge of his duties and for conducting the administrative affairs of the Association.

Article VIII
HOUSE OF DELEGATES

The House of Delegates shall be the legislative, business, and policy-making body of the Association and shall consist of (1) delegates selected by the component societies under authorized apportionment, (2) the general officers of the Association, (3) all past presidents, provided they still be members in good standing of the Association, (4) members of the Board of Trustees and Councils, and (5) elected committees, Delegates and Alternate Delegates to the American Medical Association, members of the State Board of Health, and members of the Board of Trustees of Mental Institutions, all of whom must be members of this Association.

Article IX
BOARD OF TRUSTEES

The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of nine members, one from each Association District, elected for terms of three years each. A Trustee shall not serve more than three consecutive terms.

Article X
FUNDS AND EXPENSES

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by annual dues, per capita assessments upon the membership, and by voluntary contributions. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, publications, and for any other purpose approved by the House of Delegates.

Article XI
THE SEAL

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII
AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been sent officially to each component society at least two months before the session at which final action is taken.

BY-LAWS

Chapter I
MEMBERSHIP

Section 1. Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriately accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate must be legally licensed to practice medicine in Mississippi. Persons who obtained this degree prior to January 1, 1917, need not comply with this requirement but must be licensed to practice medicine in Mississippi or, if offering to practice in Mississippi must be eligible for license by reciprocity and be a member in good standing of a constituent (state) association of the American Medical Association. Membership in a component society, evidenced by the payment of dues for the current year, shall be a prerequisite to membership in the Association, except that a physician upon his initial application for membership in a component society of the Association shall be required to undergo a waiting period of ninety (90) consecutive days from the date he begins the practice of medicine in the geographical area of the component society before he may be elected to membership in the component society. No physician shall be eligible for membership who has been convicted of or who has plead guilty to either a felony or a violation of a state or federal narcotics law. The duly certified court record shall be *prima facie* evidence of pleas and convictions and cause automatic revocation of membership. No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp, provided, however, that physicians in full time government service who need no registration to use, prescribe, and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity, or retirement, neither prescribe nor dispense narcotics and who for this reason alone have not applied for registration shall be exempt from this requirement.

Section 2 (a). Good Standing. Only those members in good standing shall be entitled to the rights and privileges of membership. A physician not in good standing may not be elected to office nor exercise the privilege of voting or attending any session of this Association, scientific or otherwise. The name of a physician upon the properly certified roster of a component society which has paid its annual assessment shall be *prima facie* evidence of his right to register at the annual session of the Mississippi State Medical Association. No member shall participate in any of the proceedings of the annual session until he is duly registered. No delegate or other member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section. (b) Change of State Residence. In the event that a member moves from the State, his membership shall continue until, and lapse at the end of, the current fiscal year, but this provision shall not operate to prevent a physician who moves from the state continuing his membership by payment of all dues and assessments to the state Association. (c) Obligations of Membership. When the Executive Secretary of the Mississippi State Medical Association is officially informed by the secretary of a component society that a physician is not in good standing in the component society, he shall remove the name of the physician from the rolls of the Association. A member shall hold his membership through the component society in the jurisdiction of which he practices, provided that a physician living on or near a county line may hold membership in the society most convenient for him to attend. If the society in which he chooses to secure membership does not exercise jurisdiction over the area of his residence, then permission must be obtained from the jurisdiction society to facilitate his affiliation with the extra-jurisdiction society.

Section 3. Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications: Active, emeritus, and associate. (a) Active Membership. Active members shall include all eligible members of component societies in good standing, providing that all dues and assessments in this Association as may be hereinafter prescribed have been received by the Association. (b) Emeritus Members. Any members of the Mississippi State Medical Association who has been an active member for any ten consecutive years and shall have permanently retired from the practice of medicine shall be eligible for election to emeritus membership. Election to emeritus membership for reason of retirement in the case of permanent and total disability shall merit special consideration but shall be subject to ruling by the Board of Trustees. Election to emeritus membership shall be based on the recommendation of the component society and the approval of the Board of Trustees. (c) Associate Membership. Any commissioned medical officer in the United States Army, United States Air Force, United States Navy, or United States Public Health Service, or any physician in the employ of the Veterans Administration, not licensed to practice in the State of Mississippi, stationed in Mississippi, members of medical faculties of medical schools in Mississippi, approved by the American Medical Association, who are not licensed to practice in the state, any hospital intern, or any hos-

pital resident in Mississippi, may, on election to associate membership by the component society in whose jurisdiction the physician resides become an associate of the Mississippi State Medical Association. Associate members shall not vote or hold office.

Section 4. Dues and Assessments. A per capita assessment determined by the House of Delegates shall constitute the dues of the Association, which assessment shall be collected from all active members by the respective secretaries of the component societies, provided that new members shall be accepted on payment of three-fourths of annual dues after May 1 and one-half of annual dues after September 1. Each active member shall pay the prescribed dues to the officer designated by the component society for transmittal to the Executive Secretary of the Association. Dues shall include a subscription to the official publication of the Association. (a) Members Excused From Payment. The Board of Trustees may, by majority vote, excuse a member from payment of dues because of undue hardship or similar circumstances warranting special consideration provided that the component society shall have excused in full the payment of dues for periods exceeding one year. Such circumstances shall be interpreted to include extended illness and temporary disability. (b) Emeritus Members. Physicians who have been elected emeritus members shall not be required to pay dues in the Association. (c) Payment of Dues and Delinquency. Dues of the Association are due and payable on December 31 of the year prior to that for which dues are prescribed. Failure to pay dues by April 1 of the year for which due shall result in forfeiture of membership privileges and the removal of the member's name from the rolls of the Association. A five dollar ($5.00) reinstatement cost shall be assessed against any member who is delinquent by reason of non-payment of dues after April 1 of the year for which dues are payable. A member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from military service.

Section 5. American Medical Association. Members of this Association shall pay the dues or hold a legal exemption from the dues of the American Medical Association. These dues shall be paid through the component society to the Executive Secretary of the Mississippi State Medical Association, whose duty it shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor.

Section 6. Revocation of Emeritus or Associate Membership. Any emeritus or associate membership may be revoked by two-thirds vote of the House of Delegates when, in the opinion of the House of Delegates, the conduct or actions of the emeritus or associate member violates any of the principles of the code of ethics or whose conduct or actions are not becoming to the honor conferred.

Chapter II

ANNUAL AND SPECIAL SESSIONS

Section 1. Time and Place. An annual session shall be held as required by Article V, Section 1, the Constitution of the Mississippi State Medical Association. which session shall in any event be held prior to the annual session of the American Medical Association. The place of the state session shall be fixed in accordance with Article V, Section 2, the Constitution of the Mississippi State Medical Association.

Section 2. Special Session. A special session of the Association or of the House of Delegates may be called by the President, with the approval of the Board of Trustees. The Board of Trustees is empowered to call a special session by majority concurrence.

Section 3. Inviting an Annual Session. A component society desiring the Association and House of Delegates to meet in annual session in a city within its jurisdiction may submit an invitation in writing or verbally through its representative to the House of Delegates at the annual session concerned with the selection of the site for the next regular scheduled meeting. The dates and site of the annual session selected may be changed by majority vote of the Board of Trustees in an emergency requiring such a change.

Section 4. Registration Privileges. Only the following shall be permitted to register at any session:

(a) Active members
(b) Emeritus members
(c) Associate members
(d) Invited guests
(e) Medical students of American Medical Association approved medical schools who are certified to the Executive Secretary of the Association by their respective deans.
(f) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the Executive Secretary of the Association by their respective hospital superintendents in event they are not associate members of the Association.
(g) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the Executive Secretary by their Post or Base Surgeons or Commanding Officers.

Section 5. Indebtedness. A member shall not be permitted to register unless all current indebtedness to both the Association and component of proper jurisdiction has been paid.

Section 6. Admittance. Admittance to any meeting of the House of Delegates, any scientific section, or any of the various exhibits at an annual session of the Association shall be limited to members in good standing, duly registered and invited guests, members in good standing of the Woman's Auxiliary to the Mississippi State Medical Association, duly accredited and registered members of the Press, and accredited technical and scientific exhibitors.

Chapter III

GENERAL MEETING

Section 1. Participation. The general meeting shall include all registered members and guests, who shall have equal rights to participate in the proceedings and discussions, but no member shall vote on any question coming before a section of the general meeting except those who have registered as members of such sections. Each section of the general meeting shall be presided over by its chairman. The address of the President and the Distinguished Service Oration shall be delivered before the general meeting at such time and place as may be arranged.

Section 2. Order. The order of exercise, papers, and discussions as set forth in the official program shall be followed from day to day until it has been completed. But no section shall be allowed to place more than five papers on its program, nor more than two invited guest essayists (out-of-state or non-member). When a section program is not completed within the time assigned, it shall not be allowed to continue into that assigned to another section.

Section 3. Time Restrictions. No address or paper before the Association, except those of the President and Orator, shall occupy more than twenty minutes in its delivery, except that guests may be allowed thirty minutes; and in formal discussion no one shall speak more than five minutes; and in informal discussion no one shall speak more than three minutes and not more than one time.

Section 4. Essayists. With the exception of the invited guests, the essayists must be members of the Association. No name shall appear more than once on the printed program to discuss a paper before the regular scientific sections unless such person qualifies for membership as provided in these By-Laws.

Section 5. Papers. All papers read before the Association shall be its property. Each paper must be read by its author, and must be deposited with the Secretary when read.

Section 6. Failure to Read Paper. No author listed on the program who fails to read a paper at the session may be allowed a place on the program of the next annual session, but if the author, being unable to attend, shows his good intent by forwarding his paper to the Secretary before the annual session, he shall not suffer the penalty.

Chapter IV
SCIENTIFIC SECTIONS

Section 1. Designation of Sections. The scientific sections of the Association shall be as follows: (a) Section on Medicine, (b) Section on Surgery, (c) Section on Preventive Medicine, (d) Section on Eye, Ear, Nose and Throat, (e) Section on Pediatrics, (f) Section on Obstetrics and Gynecology, and (g) Section on General Practice.

Section 2. Section Officers. Each scientific section of the Association shall, as the last order of business during its regular meeting, elect a chairman who shall serve for a period of one year. A majority of votes cast shall be necessary to elect. Additionally, each section shall elect a secretary whose term of office shall be for a period of three years and so arranged that secretaries shall be elected by their respective sections at the same annual meeting as follows: (1) Sections on General Practice and EENT, (2) Sections on Obstetrics and Gynecology and Preventive Medicine, and (3) Sections on Pediatrics, Surgery, and Medicine.

Section 3. Program. The Council on Scientific Assembly shall place any paper in its proper section. The Council shall so arrange the program that no one section shall be given precedence over others two years in succession.

Chapter V
HOUSE OF DELEGATES

Section 1. Apportionment and Representation. Each organized county shall be entitled to representation in all regular and special sessions of the House of Delegates, one delegate and one alternate for each fifty members in the county and one delegate and one alternate for each fraction thereof, but each organized county holding a charter from this organization having made its annual report and paid its assessments, as provided in this Constitution and By-Laws shall be entitled to at least one delegate and alternate, said alternate delegates to act only in the absence of the delegate or delegates from the respective counties. No county in a component society shall be without representation in the House of Delegates; each shall be entitled to one delegate and one alternate without regard to total membership. No alternate may be seated at any regular or special session of the House of Delegates unless the delegates elected from that county shall be absent or otherwise unable to participate in the proceedings. In the event that neither the delegate nor the alternate is able to attend the regular or special session to which they have been accredited, then any *bona fide* resident of the county may, if properly registered, qualify himself as a delegate. No representative of the component society shall be seated in the House of Delegates until all his dues, assessments, and obligations to the component society have been paid. Delegates and alternates shall be elected by their respective component societies for terms of not less than two years and shall assume office on the first day of the annual session following their elections; they shall be *bona fide* residents of the counties which they represent. Their names shall be reported to the Central Office of the Association not later than thirty days prior to the first day of the annual session. Representatives of component societies shall be seated in the House of Delegates only following their proper registration of credentials from the component societies they represent.

Section 2. Meetings and Attendance. The House of Delegates shall meet annually on the first day of the annual session of the Association. The House of Delegates shall meet for the conclusion of business on the last day of the annual session immediately following the adjournment of the last general or scientific session, provided that these requirements shall not operate to prevent such other meetings of the House of Delegates during the annual session as the House itself may order or the President or Speaker may deem necessary, but no such meetings may be called at times which would conflict with the scheduled general or scientific session. Duly registered members and guests may attend all meetings of the House of Delegates provided that they occupy a distinctly separate section of the meeting hall or auditorium and further provided that they shall not be permitted to participate in any phase of the meeting of the House of Delegates except on invitation of that body. By majority vote, the House of Delegates may enter into executive session, during which time only qualified delegates and officers of the Association may remain in attendance.

Section 3. Quorum. A three-fifths majority of registered and duly seated delegates of this Association shall constitute a quorum.

Section 4. Order of Business. The order of business shall be conducted at the pleasure of the House of Delegates, provided it shall not be in conflict with either these By-Laws or the Constitution. Meetings shall be conducted according to *Robert's Rules of Order, Revised,* and within the bounds of courtesy and this Constitution and By-Laws. Generally, the order of business shall be:

(1) Adoption of the Transactions of the previous meeting.
(2) Reports of Boards, Councils and Committees.
(3) Reports of Presidential Committees.
(4) Special Orders.
(5) Unfinished Business.
(6) New Business.

Section 5. Memorials and Resolutions. No memorials or resolutions shall at any time be issued in the name of the Mississippi State Medical Association by any officer or member thereof until such memorial or resolution has been approved and adopted by the House of Delegates or Board of Trustees.

Section 6. Duties and Responsibilities. It shall, through its officers and otherwise, give diligent attention to foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest. It shall consider and advise the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto. It shall make careful inquiry into the condition of the profession of each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in the counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county in the state has been brought under medical society influence. It shall encourage postgraduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the component

societies. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two successive years. It shall, upon recommendation of the Board of Trustees, provide and issue charters to counties organized to conform to the spirit of the Constitution and By-Laws.

Section 7. Reference Committees. Business brought before the House of Delegates will normally be referred by the Speaker for hearing, debate, and recommendation to a reference committee. Sufficient reference committees shall be appointed by the President to expedite and assist in the deliberations of the House of Delegates. Such committees shall consist of not less than three nor more than five members, all of whom shall be members of the House of Delegates, who shall serve only during the regular or special session for which appointed. Any member of the Association shall have the privilege of appearing before a reference committee on any issue being considered. Additionally, reference committees may permit the appearance of any individual who, in the opinion of the committee, can assist its deliberations.

Chapter VI

ELECTION OF OFFICERS

Section 1. Ballot. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect.

Section 2. Nominations. The House of Delegates, at the adjourned meeting of the annual session, shall select a Nominating Committee consisting of nine members of the House, one from each association district and each eligible to serve as a member of the House at the next annual session. Selection of committee members shall be made in district caucuses, and the committee shall elect its chairman. It shall be the duty of the committee to consult with members of the association through their respective component medical societies; to consult prospective nominees for office as to their willingness and ability to serve, if elected; to conduct a formal meeting at least three months prior to the annual session at which elections are to be held and to agree upon a slate of nominees at this meeting; and to publish to the membership this slate of nominees not later than one month prior to the next annual session. The committee shall nominate to the House of Delegates three members for each general officer vacancy and two names for all other offices. No two candidates for President-elect shall be named from the same county. Nominations for appointment to membership on the Mississippi State Board of Health shall be made in accordance with Section 7024, Mississippi Code of 1942, Recompiled, provided that six names shall be submitted, three of whom shall be elected and their names submitted to the Governor as nominees from each public health district. Five members shall be nominated for a vacancy occurring on the Board of Trustees of Mental Institutions which nomination shall be submitted to the Governor in accordance with law.

Section 3. Report of Nominations. The House of Delegates shall receive the report of the Committee on Nominations and elect officers, Trustees, and Council members on the last day of the annual session.

Section 4. Nominations from the Floor. Nothing in this Chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 5. Executive Secretary. The Board of Trustees shall select and appoint an Executive Secretary as elsewhere prescribed in the Constitution and By-Laws of the Association.

Chapter VII

DUTIES OF OFFICERS

Section 1. President. The President shall have general supervision over all meetings of the various bodies of the Association, shall appoint all committees not otherwise provided for, shall deliver an annual address at such time and place as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall fill by appointment all vacancies occurring during his tenure of office among the general officers and on the Board of Trustees and Councils and shall be empowered to appoint such committees on an *ad hoc* basis as may be desired or required to conduct the affairs of the Association. He shall be an *ex officio* member of all Councils and committees. He shall be the real and acknowledged head, as well as the personal representative, of the medical profession of the State of Mississippi during his term of office, and insofar as practicable, shall visit by appointment the various sections of the state and the component societies of the Mississippi State Medical Association and assist the Trustees in their tasks of aiding and strengthening the component societies and in making their work more useful.

Section 2. President-elect. The President-elect shall be in charge of the work of organization, including membership, under the direction of the President, and shall exercise these duties and advise with the Vice Presidents and with the Board of Trustees in this phase of their activity. He shall be an *ex-officio* member of all Councils and committees. He shall succeed to the presidency upon the event of the death, resignation, or removal from office of the President. This automatic succession shall not operate to disqualify him from serving the next regular term of office unless he has served more than six months as President.

Section 3. Vice Presidents. The Vice Presidents shall assist the President in the discharge of his duties. They shall further assist the President-elect in the work of organization, including membership in their respective areas, and in promoting the welfare of the Association and the profession of the state.

Section 4. Speaker. A Speaker shall be elected for a term of three years. This officer may be chosen from the membership of the Association, irrespective of any affiliation with the House. The Speaker shall familiarize himself with the rules and usages of parliamentary procedure, with the laws of the House. On him shall devolve the duty of bringing before the House through the various officers and chairmen all reports and other matters that are to receive its attention. He shall preside at all meetings of the House and perform the duties usual to the position and office of chairman except in the appointment of committees, which shall be the privilege of the President.

Section 5. Vice Speaker. A Vice Speaker shall be elected for a term of three years to run concurrently with that of the Speaker. The Vice Speaker shall assist the Speaker in all duties prescribed in these By-Laws.

Section 6. Secretary-Treasurer. The Secretary-Treasurer shall be elected for a term of three years. He shall perform such duties ordinarily devolving on a secretary of a corporation by law, custom, or parliamentary usage and shall enjoy the rights and perform such other duties as may be granted or imposed in the Constitution and these By-Laws. He may delegate such duties as are herein described to the Executive Secretary who shall be responsible therefor. He shall be an *ex-officio* member of all Councils and committees.

Section 7. Executive Secretary. The Executive Secretary shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. He need not be a member of the Association nor a physician. He shall maintain a Central Office for the Association and shall be responsible for the management and proper functioning of the Central Office to the President of the Association and the Board of Trustees. He shall attend all sessions

and meetings of the Association, the House of Delegates, the Board of Trustees, and shall serve at all times to perform such other duties as may be deemed beneficial to the Association by the President and Board of Trustees. He shall assist elected officers, Councils, committees, and Trustees in the performance of their duties. Under instructions from the President, he shall conduct a comprehensive program of public education and all such other activities as may disclose favorably to the public at large the aims, objectives, and goals of service of the medical profession in Mississippi. He shall, when requested, place himself in position to assist any of the component societies of the Association and he shall attend meetings of the component societies when invited by officers thereof. He shall be made custodian of records, books and papers belonging to the Association and he shall keep account of and promptly place under the supervision of the Secretary-Treasurer such funds as may be delivered into his hands in the name of the Association. He shall give bond at the expense of the Association in such amount as may be required. He shall provide for the registration of the members and delegates at the annual session and cooperate in preparing for and arranging all functions of the Association, including the annual session. He shall procure an exact transcript of all proceedings of the House of Delegates. He shall maintain a register of all legal practitioners in Mississippi and he shall maintain detailed and exact records of the membership with regard to component societies, the Mississippi State Medical Association, and the American Medical Association. He shall issue evidence of membership to each physician who pays the annual assessment and is accepted in the Mississippi State Medical Association. He shall maintain close and complete liaison with the American Medical Association and shall keep the component societies informed of activities, programs, and mandates of both the state Association and the American Medical Association. He shall publish from the Central Office such memoranda, bulletins, and miscellaneous publications as may be directed by the President, the Board of Trustees, and the House of Delegates. He shall conduct the official correspondence of the Association as he may be directed. He shall employ such assistants as may be required, upon authorization of the Board of Trustees. He shall supply each component society with blank forms to be used in connection with membership and reports. He shall maintain records of monies paid by the component societies for assessments and dues. He shall prepare and publish under the direction of the President and Board of Trustees such programs as may be necessary for official functions of the Association. He shall be reimbursed for expenses incurred in the performance of his duties, separately and in addition to his regular compensation.

Chapter VIII

BOARD OF TRUSTEES

Section 1. Board of Trustees. The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates. It shall consist of nine members, one from each Association District, where terms of office shall be three years and so arranged that only three members are elected annually. A Trustee shall not serve more than three consecutive terms. During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect.

Section 2. Officers of the Board. The Board of Trustees shall elect from its membership a Chairman, a Vice Chairman, and a Secretary for terms of one year during the last day of the annual session following adjournment of the House of Delegates. These officers of the Board shall compose its Executive Committee. The duties of the Secretary may be delegated to the Executive Secretary who shall maintain such special records and transcripts of meetings as the Board may desire.

Section 3. Meetings of the Board. The Board of Trustees shall meet daily during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of any three members of the Board.

Section 4. Executive Committee. The Executive Committee of the Board of Trustees shall be empowered to act in behalf of the Board on all matters delegated to it by majority vote of the Board. The acts of the Executive Committee, however, shall be subject to confirmation by the Board.

Section 5. Reports of the Board of Trustees. The Board of Trustees shall make an annual report to the House of Delegates and such supplemental reports as necessity may require at a time designated in the regular transaction of the business of the House. The report shall be made by the Chairman, the Vice Chairman, the Secretary, or the Executive Secretary. The reports of the Board shall be made a portion of the annual transactions and proceedings of the Association.

Section 6. Duties of Trustees. Each Trustee shall be organizer and arbiter for his Association District. He shall visit the component medical societies within his District during each year and shall make an annual report of his activities and of the condition of the medical profession of each county of his District. Each Trustee shall be reimbursed for expenses incurred by him in traveling within his District or attending special meetings in the performance of his official duties, which will be allowed upon presentation of an itemized and documented account. This provision shall not be construed to include his expenses in attending the annual session of the Association.

Section 7. Public Policy. The Board of Trustees shall have the right to communicate the views of the medical profession and of the Association in the State of Mississippi with regard to matters of medical science, health, sanitation, and allied spheres of activity. It shall approve all memorials and resolutions issued but shall not issue memorials and resolutions heretofore prohibited in these By-Laws.

Section 8. Association Districts. The State of Mississippi shall be subdivided into Association Districts by counties, provided that all counties in a component society shall be in one Association District. These districts are defined as follows:

District 1:	Bolivar, Coahoma, Humphreys, Leflore, Quitman, Sunflower, Tallahatchie, Tunica. and Washington.
District 2:	Benton, DeSoto, Lafayette, Marshall, Panola, Tate, Tippah, Union, and Yalobusha.
District 3:	Alcorn, Calhoun, Chickasaw, Clay, Itawamba, Lee, Lowndes, Monroe, Noxubee, Oktibbeha, Pontotoc, Prentiss, and Tishomingo.
District 4:	Attala, Carrol, Choctaw, Grenada, Holmes, Montgomery, and Webster.
District 5:	Hinds, Issaquena, Leake, Madison, Rankin, Scott, Sharkey, Simpson, Smith, Warren, and Yazoo.
District 6:	Clark, Kemper, Lauderdale, Neshoba, Newton, and Winston.
District 7:	Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, and Wayne.
District 8:	Adams, Amite, Claiborne, Copiah, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson.
District 9:	Hancock, Harrison, Jackson. and Stone.

Chapter IX
COUNCILS

Section 1. Councils. Councils of the Association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical Service, a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A Council member shall not serve more than three consecutive terms.

Section 2. Council on Medical Service. The Council on Medical Service shall be charged with the responsibilities of ascertaining and studying all aspects of medical care in Mississippi. It shall examine and make available all facts, data, and opinion on timely and adequate medical care. It shall investigate social and economic aspects of medical care and report its evaluations and findings. It shall suggest means of distribution of adequate quality medical service to the public consistent with the policies of the Association. It shall act as a factfinding and advisory body of the Association. Under its jurisdictions, there shall be assigned the activities of the Association in medical service, emergency service programs, indigent care, and allied medical agencies. There shall be one member from each Association District elected for a term of three years and so arranged that only three members shall be elected for full terms each year. The Council on Medical Service shall appoint Committees on Occupational Health, Maternal and Child Care, and Mental Health. Each committee shall consist of not less than five nor more than seven members appointed for periods of not less than one nor more than three years.

Section 3. Council on Scientific Assembly. The Council on Scientific Assembly shall be composed of the Secretary-Treasurer and the chairman and secretaries of the several scientific sections. The Secretary-Treasurer shall be chairman of the Council. Upon this Council shall devolve the duties and responsibilities of planning the annual session to include all scientific activity and the programming and scheduling of annual session events. The Council shall be empowered to appoint such committees for terms not to exceed one year as may be necessary to assist in the discharge of these duties.

Section 4. Judicial Council. The Judicial Council shall consist of nine members elected for terms of three years each, one from each Association District. The judicial powers of the Association shall be vested in this Council whose decision shall be final. The Council shall have jurisdiction in all questions involving membership in the Association, all controversies arising under the Constitution and these By-Laws, interpretation and application of the Principles of Medical Ethics of the American Medical Association, controversies between two or more component societies of the Association and among members of the Association. The Council shall have appellate jurisdiction in questions and controversies referred to the state Association by appropriate and authorized bodies of component medical societies. Appeals shall be perfected within six months following the date of decision by the constituted authority of the component society. The Council, under these several authorities, may conduct such hearings as may be necessary and after due and legal processes may, by majority opinion, censure, suspend, or expel any member for infraction of the Constitution or these By-Laws.

Section 5. Council on Constitution and By-Laws. The Council on Constitution and By-Laws shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be referred all suggested amendments and changes in the Constitution and By-Laws of the Association for recommendation to the Board of Trustees and House of Delegates.

Section 6. Council on Legislation. The Council on Legislation shall consist of nine members, one from each association district, elected by the House of Delegates for terms of three years each which are so arranged that three members are elected annually. This Council shall analyze proposed legislation, recommending to the Board of Trustees courses of action for securing laws in the interests of public health, scientific medicine, as well as medical practice. It shall study and report the need for new and remedial legislation designed to serve the best interests of the state and nation. This Council shall be responsible to the Board of Trustees.

Section 7. Council on Budget and Finance. The Council on Budget and Finance shall consist of three members elected by the House of Delegates for terms of three years each. This Council shall receive reports of the finances of the Association and to it shall be referred all matters pertaining to the annual budget. The Council shall report annually to the House of Delegates, making specific recommendations on the annual budget of the Association. This Council shall be responsible to the Board of Trustees.

Section 8. Editorial Council. The Editorial Council shall consist of the Editor and the Associate Editors, elected by the House of Delegates to serve two years, and the former shall serve as chairman. To this Council shall be referred all reports of scientific subjects and all scientific papers and discussions presented before the Association and its component societies. The Council shall consider for publication in the official organ of the Association such papers, reports, and other data as may serve to further and advance scientific medicine in Mississippi. It shall exercise editorial authority over the official organ of the Association. This Council shall be responsible to the Board of Trustees.

Section 9. Council on Medical Education. The Council on Medical Education shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This Council shall be responsible to the Board of Trustees.

Chapter X
COMMITTEES OF THE BOARD OF TRUSTEES

Section 1. Committees of the Board of Trustees. Standing committees of the Board of Trustees shall consist of the Advisory Committee to the Medical Auxiliary, Grievance Committee, the Committee on Publications, and the Committee on Medicine and Religion. All committees of the Board of Trustees shall be appointed by the Board for terms specified unless their selection is otherwise prescribed.

Section 2. Advisory Committee to the Medical Auxiliary. The Advisory Committee to the Medical Auxiliary shall consist of three members appointed for terms of three years each. The committee shall be charged with the responsibility of advising the Woman's Auxiliary to the Mississippi State Medical Association on matters of organization and program activity relating to the supportive role of the Auxiliary in its work with the Association.

Section 3. Grievance Committee. The Grievance Committee shall be appointed by the President with the advice and consent of the Board of Trustees. Its purpose shall be to prevent or resolve misunderstandings, to clarify and adjust differences between physician and patient, and to assist in maintaining the high levels of professional deportment already established by the *Principles of Medical Ethics*. The committee shall consist of nine members, one from each Association District, appointed for terms of three years each so as to provide

for appointment of three members annually. Members of this committee shall not simultaneously serve on any disciplinary or appeal body of the Association or its component societies. The committee shall have authority to compel a response either in writing or by personal appearance from any member of the Association, authority to initiate investigations on its own motion, and authority to file charges in the name of the committee before the Judicial Council of the Association. Under no circumstances shall the Grievance Committee ever exercise a disciplinary function and its power and authority shall be limited to the receiving of complaints, conduct of investigations, hearings, mediation, arbitration, and where necessary, referral of matters to appropriate bodies for adjudication or discipline. The committee shall prescribe its rules for operation which shall not be in conflict with generally accepted guides promulgated by the American Medical Association.

Section 4. Committee on Publications. The Committee on Publications shall consist of six members. These shall consist of the Editor, the two Associate Editors, and three others, the three latter being appointed by the Board of Trustees for terms of three years which are so arranged to provide for appointment of one such member annually. The chairman of the committee shall be designated by the Board. The committee shall implement instructions and policies of the Board of Trustees relating to the official Journal of the Association. Additionally, the committee shall study and recommend to the Board policy proposals relating to organization and production of the Journal, reporting annually its deliberations.

Section 5. Committee on Medicine and Religion. The Committee on Medicine and Religion shall consist of six members appointed for terms of three years each and so arranged to provide for appointment of two members annually. The committee shall be responsible for formulating a program in the field of medicine and religion and for carrying out such assignments as may be made in this connection by the Board of Trustees.

Chapter XI
RULES AND CONDUCT

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Chapter XII
COMPONENT SOCIETIES

Section 1. Component Societies. All component societies now in affiliation with this Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Board of Trustees and approval by the House of Delegates, receive a charter from and become a component part of this Association. The Board of Trustees and House of Delegates, on recommendation by the Judicial Council, shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Section 2. Number of Societies. Only one component medical society shall be chartered in any county but nothing in this section shall be construed as to prohibit unofficial organization of medical clubs or other county level groups of physicians whose purpose it is to further and advance scientific medicine and postgraduate medical education.

Section 3. Members of Societies. Each component society shall judge the qualifications of its own members, but as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who is qualified under Chapter I, Section 1, of these By-Laws shall be eligible for election to membership. Before a charter is issued to any component society, full and ample opportunity shall be given to every such physician in the county to become a member.

Section 4. Right of Appeal. Any physician who may feel aggrieved by the action of the society of his county or District in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Judicial Council, which, upon a majority vote, may permit him to petition for membership in an adjacent society.

Section 5. Evidence of Appeals. In hearing appeals, the Judicial Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts at a conciliation and compromise shall precede all such hearings.

Section 6. Area Jurisdiction. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Section 7. Professional Authority. Each component society shall have general direction of the affairs of the profession in its jurisdiction and shall constantly use its influence to the moral and professional betterment of its physicians, to the end that the membership shall embrace every qualified physician in its jurisdiction.

Section 8. Meetings. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall especially be encouraged to do postgraduate work, and to give the society first benefit of such labors. Official positions and other preferments shall be unstintingly given to such members.

Section 9. Delegates. Each county shall be entitled to representation in the House of Delegates of this Association, one delegate for each fifty members or fraction thereof. Delegates shall be elected for terms of not less than two years and societies shall report such elections to the Executive Secretary of the Association in no event later than thirty days before the annual session.

Section 10. Duties of Component Society Secretaries. The secretary of each component medical society shall perform such duties as are usual and customary to his office. He shall maintain the official roll of membership for his society, shall collect dues and assessments, and shall make official reports as elsewhere prescribed in these By-Laws to the Association, transmitting dues in behalf of component society members. He shall conduct the official correspondence of his component medical society.

Chapter XIII
FISCAL YEAR

The fiscal year of the Association and its component county societies shall begin January 1 each year and end on December 31 following, but membership in the state Association shall not lapse until April 1 of that year.

Chapter XIV
AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, after the amendment has laid upon the table for one day.

Chapter XV
REPEALING AUTHORITY

Upon adoption of these By-Laws, all previous By-Laws, motions of record, mandates, policies, rules and regulations in conflict therewith are hereby repealed, except that officers elected to serve in the Association and its component societies shall continue their incumbency until the completion of their previously prescribed terms and their successors elected under the current By-Laws.

Radiologic Seminar LXXV: Hyaline Membrane Disease

JOSEPH O. WOOD, M.D.
McComb, Mississippi

HYALINE MEMBRANE disease is one of the most common causes of respiratory distress in the newborn. If treatment is to be effective, the condition must be recognized early; yet, the chest film of any baby in the first 12 hours of life may be identical with the findings in neonatal atelectasis. Serial films, however, will reveal a worsening of the findings in this condition.

Although the etiology is unknown, its relationship to certain factors such as prematurity, diabetes in the mother, antenatal maternal hemorrhage, and cesarean-section infants has been emphasized. It has also been pointed out that there is a race difference. For example, studies have shown that there are more than twice as many Negro infants with birth weights of 2,500 gm. than white. Yet, in this birth weight group, the neonatal death rate as well as the hyaline membrane rate is higher in white than in Negro. These rates were even higher in infants with birth weights of 1,500 to 2,500 gm. Infants weighing over 2,500 gm. show a lower death rate in whites, but the hyaline membrane rate remained about twice as high in whites.

A number of investigators have suggested that the basic and crucial abnormality in this disease may be a pathological pulmonary vasoconstriction. These investigators feel that the syndrome is caused by reflex vasoconstriction which is used to centralize the blood flow when the newborn is subjected to stresses such as hypoxemia and hypothermia. In this way the blood flow to the brain, heart, and placenta is preserved at the expense of flow to the kidney, gut and lungs—thus providing survival value in the presence of these stresses.

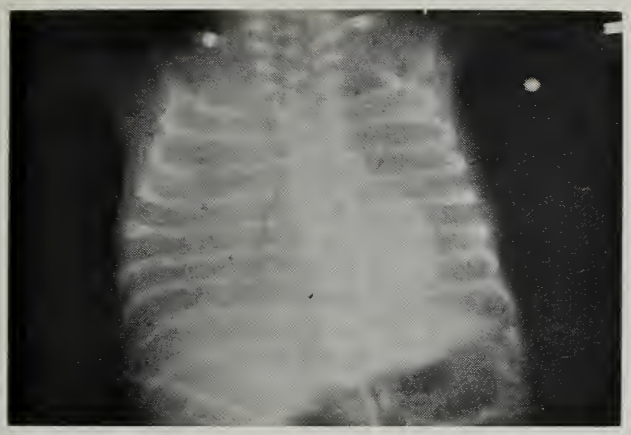
With a patent ductus arteriosus in the newborn, the alveolar capillaries may be excluded from the blood flow by pulmonary vasoconstriction, with resulting ischemic damage to the lungs. The pathogenetic sequence in hyaline membrane disease has been summarized as follows: pulmonary vasoconstriction—alveolar hypoperfusion—deficient anabolism—alveolar cells (surfactant—deficient alveolar surfaces—atelectasis)—increased alveolar wall permeability—effusion into interspaces—fibrin deposition. It has been suggested that the syndrome be renamed "the pulmonary hypoperfusion syndrome."

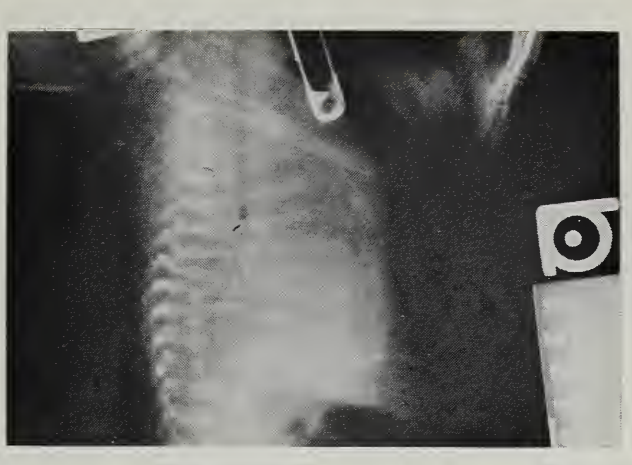
Moreover, infants with hyaline membrane disease have respiratory difficulty from birth. Shallow respiration often accompanied by expiratory grunts is seen. Varying degrees of cyanosis are seen. The baby often has edema of the hands and feet, bowel sounds are diminished, and defecation and diuresis may be delayed. The severity of the syndrome varies from mild and transient postnatal respiratory difficulty to rapidly progressing distress and death within 24 or 48 hours.

The chest x-ray is consistent with hyaline membrane disease and also usually rules out other causes of respiratory distress. The x-ray in hyaline membrane disease shows generally increased density over the lungs, and the density has a reticular or granular pattern. This granular pattern is caused by collapsed alveoli surrounded by dilated alveolar ducts and terminal bronchioles. Because of coalescence of the small granular densities, the pattern becomes coarser and may obscure the bronchial tree.

Hyaline membrane disease has been treated with mechanical inflation of lungs, administration of aerosolized surface active material or fibrinolytic enzymes, intravenous bicarbonate, glucose solutions, oxygen and other conservative therapy. This therapy is directed toward pulmonary atelectasis with deposition of fibrin in airspaces. Alveolar perfusion can be increased by infusion of

Sponsored by the Mississippi Radiological Society.





AP and lateral views of the chest of a 24-hour-old infant revealing advanced changes associated with hyaline membrane disease. There is almost homogenous opacity with a well-defined air bronchogram. This baby died at 48 hours.

acetylcholine or sodium bicarbonate, or by raising the oxygen tension in inspired gas.

Prophylactically, maternal hypoxia, acidemia, and systemic hypotension with decreased uterine blood flow, however, should be avoided. The infant should be watched closely for intervals of apnea and increasing oxygen given if these become longer. Respiratory stimulants or assistance may be needed. Undue chilling may provoke acidemia and pulmonary vasoconstriction. Better therapy may be forthcoming, particularly in the field of pulmonary vasodilatation.

In summary, it is felt that with prophylactic measures, early recognition and prompt therapy it may be possible to salvage a significant number of newborn infants in this group. ★★★

400 Delaware Ave. (39648)

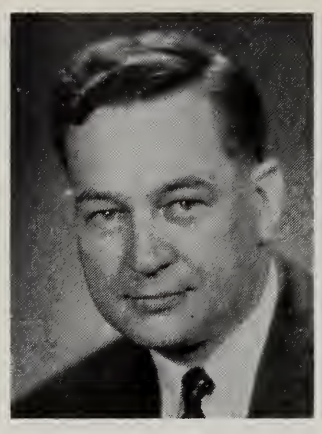
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FRUG LEGS

The physician attending a medical meeting visited a local discotheque to see the unorthodox sights of current dance crazes. A beautiful girl stopped him and said, "Thanks for the dance."

"Dance?" retorted the amazed doctor. "I was just pushing my way through the crowd to get to the men's room."



The President Speaking

'Staff Discussions'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

THE MOST PERPLEXING and difficult problems confronting American medicine are almost totally apart from science. This is to say that it is far less a matter of decision and concern as to *what* shall be done in providing care rather than the circumstances under which or, more succinctly, *how* it shall be done.

Commenting in this same vein at the recent San Francisco annual convention, the AMA Board of Trustees said that "medicine no longer functions in the sober privacy of its scientific and ministering roles. Health and life are the most urgently desired of all of people's expectations. They involve every person. And they therefore arouse the most emotion-laden concerns and scrutiny."

Physicians can and must meet this challenge which has stripped away the mystique of healing, couching it in an environment of cost evaluation, complex medical facilities, organization and delivery of health care, and financing. We physicians may prefer to leave all of this to others, cloistering ourselves in an ivory tower of science, but this is no more possible than it is practical.

In a nutshell, we will play a rightful, legitimate role in the resolution of these questions, or the role will be played for us by others.

Almost every physician can agree that we are insufficiently informed on the socioeconomic issues. It isn't that we are incapable of becoming experts, indeed, the best in the world are physicians. But the demands of practice are such as to limit our time for nonscientific learning rather strictly.

It is planned to begin publication of a news bulletin from the offices of your association to furnish background information for discussion at hospital staff meetings, and it is my suggestion that a portion of each meeting be reserved for such discussion. If this can be carried out, we physicians will possess greater understanding of the *how* of medical care. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

Volume IX, Number 7
July 1968

EDITORIALS

Fewer Births, Fewer Deaths Still Add Up to 200 Million

I

A STRANGE COMBINATION of demographic factors boosted the population of the United States to 200 million persons last year. Fewer babies were born, fewer individuals died, over 100,000 members of the armed services were sent overseas, and everybody seems to be living longer. So, for the first time in the history of the republic, the total continental population will exceed the frequently used 200 million mark during 1968.

In a decade, the nation's population has grown from 173.5 million to its present level. The growth rate has assumed a new dimension, because the birth rate continues to decline. Part of the increase, then, is dependent upon longevity, and medical science is seeing to this with keen efficiency.

The 1967 growth increment of the population was a modest 1.1 per cent, about the same as that for 1966, in spite of there being a million fewer babies born during 1967. Of the 50 states and District of Columbia, all but eight, Maine, Iowa, North and South Dakota, Nebraska, West Virginia, Montana, and Wyoming, gained in population. None of the eight losers except Wyoming suffered as much as 1 per cent loss. The glitter of Nevada, with the highest per capita income, neon-lit casinos, and agreeable arid climate, brought the greatest percentage growth of any state.

The Pacific and South Atlantic states are growing, the South is holding its own, but they are leading the nation's Midwest breadbasket, New England, and Appalachia.

II

About 3.52 million births were registered in the United States during 1967, down more than a million from 1966 and the third successive year when newborn Americans numbered less than 4 million. But the babies born in 1967 have good health going for them, because infant mortality fell to the new low of 22.1 per 1,000 live births from the 1966 low of 23.6 per 1,000 live births. This infant mortality rate is a sixth below that of a decade ago and only half of what it was at the end of World War II.

The maternal mortality rate is similarly down with a four-fold decrease from the end of World War II through the ensuing 25 years. Excluding New Jersey which has never registered births by race, the 20 year decrease from 1945 saw a drop from 238.0 deaths per 100,000 white births to 24.2 and from 596.4 deaths per 100,000 nonwhite births to 98.1 nationally. The forward thrust in improved obstetrical care and in special programs among patients designated as high risks should improve these gains substantially.

The 1967 birth rate in the nation was 17.8 per 1,000 population, not quite double that of the crude, unadjusted death rate. The latter was

9.3 per 1,000 last year, down from 9.5 in 1966. The decrease in actual numbers of deaths was small, down to 1.85 million in 1967 from 1.86 million in 1966. The favorable trend last year was achieved, for all intent and purpose, in just eight months, because there was an increase in the death rate during the fall and winter, correctly associated with respiratory disease.

Decreases in deaths from cardiovascular-renal diseases were noted, as was true of most other causes. A single, notable exception is death from malignant neoplasms which continues an upward spiral.

III

In gaining just over 1 per cent in population during 1967, the United States depended upon an excess of about 1.67 million births over deaths and immigration of 450,000 foreign born. By regions, the Pacific Coast maintains the highest rate of population growth, almost twice the national rate. In only 10 years, California has grown by 4.8 million and has a state population approaching 20 million.

Other significant gains were registered in Arizona and Nevada, the latter being the nation's percentage leader, and Florida enjoyed roughly the same growth rate as California. But three northern states have added a million population each in the decade under study: Illinois, Michigan, and New Jersey. Every Southern state showed some gain with Mississippi tacking on 15,000 in 1967 for a growth of 0.64 per cent.

From 1958 to the present year, Mississippi's population has grown to 2,350,000 from 2,088,000, an annual geometric average of 1.22 per cent.

IV

The declining birth rate and the decreasing death rate will continue present trends, but statisticians and demographers say that it is unlikely that the United States will enjoy more than its present modest annual rate of 1 per cent in the foreseeable future. With the present growing span of human life, the generation of young Americans dating from and immediately after World War II must inevitably become older. With fewer births, the younging trend in America will recede, largely in proportion to advances in medical science and acceleration in the quantity delivery of quality medical care.

The Malthusian theory is right on schedule in Asia and most of the underdeveloped nations, but American science and technology have long since reversed the proposition of natural reproduction eating the land into poverty. For the 200 million in the United States, the prospect of long and abundant life is the best in the world.—R.B.K.

Dull Reading, Maybe, But Important to You!

By almost any measure, the Constitution and By-Laws of the Mississippi State Medical Association makes pretty dull reading. Yet, for the ninth consecutive year, the association devotes eight valuable pages in the JOURNAL to publication of these vital documents. It is a convenience to members, a communications endeavor, and a reminder that *physicians* own their state medical association.

The Constitution and By-Laws are a member's assurances of his benefits and rights of membership and forceful reminders of his obligations to his profession, to his colleagues, and to himself.

These documents figure prominently in the legal status of medical society membership and in one of the two commonly accepted legal theories of membership. The contract theory of membership is predicated on the assumption that members, each with the other, enter into a contract which is expressed in the constitution and



"If the frog dies, will you save the legs for me?"

by-laws of the organization. Each member, then, is contractually obligated to each other member to observe the duly adopted rules of the organization.

Additionally, each member is legally presumed to have knowledge of the constitution and by-laws and is bound by them. A membership organization may adopt such rules as long as they are not immoral, unreasonable, or contrary to public policy or existing laws. And such rules must be equally applied to all members.

The annual publication of the association's Constitution and By-Laws affords convenient access by each member to these documents and furnishes updated versions soon after annual consideration by the House of Delegates. At the 100th Annual Session, two amendments to the By-Laws were adopted. Section 4(c), Chapter I, was amended to permit the association to furnish the JOURNAL without charge to members who are serving temporarily in the armed services, and Section 2, Chapter VI, was substantially revised with reference to nomination of officers and others elected to office by the House of Delegates.

Take a moment to skim through the legal and contractual bases for medical organization in Mississippi. A little dull reading, maybe, but of the greatest importance to physicians and *their* state medical association.—R.B.K.

A Court Decree on Telephone Listings

The AMA guidelines laid down on physicians' listings in telephone directories have, in effect, been validated by a Florida trial court. In fact, the big component medical society in the Miami-Miami Beach area was enjoined along with the telephone company from eliminating publication of the specialty listings in the local directory.

The Dade County Medical Association, by a vote of its membership, adopted a rule that physicians' names should be listed alphabetically in the classified section of the telephone directory, permitting only the identification "practice limited to . . . " Significantly, the guidelines promulgated by the AMA Judicial Council which permit, under stated limitations, directory listing under specialty headings were not submitted to the society's membership.

In a suit against his local medical society, a physician contended that the rule affected physicians' rights to contract and to practice medicine, thereby violating their constitutional right to due process of law. The court agreed that the society's ruling was unconstitutional, claiming jurisdiction because the matter affects the public interest, health, and convenience.

Not only did the court enjoin the medical society and telephone company, but it also forbade the society to discipline a physician-member or to deny membership to an applicant physician because of a telephone directory listing. Before the judgment became final, the court made another unprecedented move in ordering its clerk to mail a copy of the decree to every physician in the county, giving each two days in which to file objections.

Generally, the ruling of the court was along the lines of the guides for directory listings laid down by the AMA Judicial Council. Perhaps the case has served a useful purpose, and almost certainly, the plaintiff would agree that it has. But for medicine, it appears wise to consult its own judicial pronouncements before begging a public washing of its own laundry.—R.B.K.

Challenge in Continuing Education

"The state of Mississippi has been a generous participant in the national lag in effective postgraduate medical education. With medical knowledge and advances accumulating at an ever-increasing rate, it is becoming increasingly difficult to defend the usual practice of four years medical school followed by 30 to 40 years of active medical practice unaccompanied by dedicated effort toward the formal acquisition of modern medical knowledge."

So begins the last chapter in the study report, "Profile of Attainment—Measure of Need," the most ambitious research project ever undertaken by the association. Conducted under the guidance and supervision of the Council on Medical Education, the project extended over 10 months and is really four studies in one. It was unanimously approved by the House of Delegates at the 100th Annual Session, and the recommendations of the council accompanying it were similarly adopted.

Beginning in this issue of the JOURNAL, a condensed version of the study report is being published as a series of major importance to postgraduate medical education in Mississippi. Within the demanding limits of space available in future publication schedules, the series will extend over four or five months. The author is the chairman of the council, Dr. William O. Barnett of Jackson, recently named to the Board of Trustees.

The first of the series in the present issue out-

lines the purposes and goals of the study and presents the unique profile of attainment among Mississippi physicians. In this unusual research project, the postgraduate achievement of each physician in the state was measured, and findings are presented by discipline. Subsequent parts will show how Mississippi physicians feel and what they desire in programs of continuing education, how the state stacks up in postgraduate opportunity for doctors of medicine, what has been discovered in other major studies, and an examination of a proposed Mississippi Postgraduate Medical Institute which would be an adjunct to the University Medical Center.

The council advanced four recommendations which were approved by the delegates at the May annual session. First, priority of the highest importance was assigned to the matter of continuing education for physicians. Second, the council said that the desires and concepts of personal need expressed by physicians ought to be carefully considered in the structuring of any postgraduate program. Third, the state medical association should secure and possess an active voice in such programs, and fourth, the proposed Institute should be brought into being.

The massive, 130-page study report was distributed in April to members of the House of Delegates for advance study before consideration at the 100th Annual Session. Now, it is being published in condensed form for all members. The findings are challenging and sometimes, a little unpleasant to contemplate. It is an important benchmark from which progress can and will be measured in future years. The Council on Medical Education and the Board of Trustees present the report as a significant document and as a challenge to meet a vital need in the advancement of the art and science of medicine in our state.—R.B.K.

POSTGRADUATE CALENDAR

PERITONITIS SEMINAR

University Medical Center, Jackson
September 13, 1968, beginning at 9:25 a.m.

Participants:

Claude E. Welch, M.D., clinical professor of surgery, Harvard Medical School, Boston, Mass.

William O. Barnett, M.D., professor of surgery. University Medical Center

John D. Bower, M.D., assistant professor of medicine, University Medical Center

J. Harold Conn, M.D., clinical associate professor of surgery, University Medical Center

James D. Hardy, M.D., professor of surgery and chairman of the department, University Medical Center

J. Harvey Johnston, M.D., clinical associate professor of surgery, University Medical Center

Edward M. Lowicki, M.D., assistant professor of surgery, University Medical Center

Albert L. Meena, M.D., clinical assistant professor of surgery, University Medical Center

Robert D. Sloan, M.D., professor of radiology and chairman of the department, University Medical Center

Hilary H. Timmis, M.D., associate professor of surgery, University Medical Center

Friday Morning

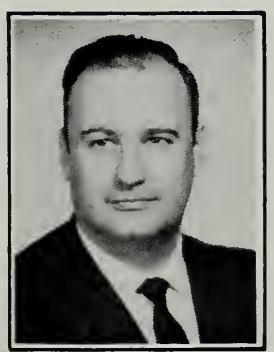
CARDIOVASCULAR DYSFUNCTION AND FLUID DISLOCATIONS IN PERITONITIS
Dr. Johnston

RESPIRATORY COMPLICATIONS OF PERITONITIS
Dr. Welch

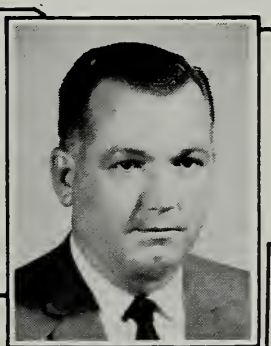


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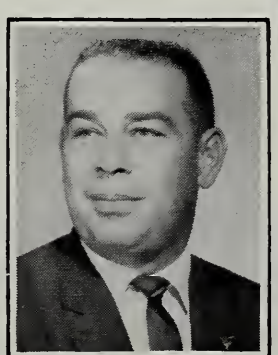


Charles Caffey
Leland
Phone 686-4753



Warren Edwards
Jackson
Phone 366-1422

Gerald Franciskato
Hattiesburg
Phone 583-2583



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POSTGRADUATE / Continued

Renal Failure in Peritonitis
Dr. Bower
Special Problems Peculiar to Peritonitis in Pediatric Patients
Dr. Meena
The Diagnosis of Peritonitis in the Unconscious Patient
Dr. Timmis
Radiographic Examinations in the Patient with Peritonitis
Dr. Sloan

Friday Afternoon

Peritonitis Secondary to Bile, Pancreatic and Gastric Leakage
Dr. Conn
Small Bowel Fistula
Dr. Hardy
Inflammatory Intestinal Obstruction Resulting from Peritonitis
Dr. Lowicki
Gangrenous Bowel Obstruction with Peritonitis
Dr. Barnett
Management of the Patient with Peritonitis from Ruptured Colon
Dr. Welch
Discussion and Questions on the Peritonitis Problem

FUTURE CALENDAR

October 3-4, 1968
Arthritis Seminar
October 15-17, 1968
Mississippi Academy of General Practice
February 6, 1969
UMC Day
February 19, 1969
Lederle Symposium
March 7, 1969
Symposium on Renal Disease
March 26-28, 1969
Cardiovascular Seminar

PERSONALS

Godfrey Arnold of Jackson appeared in piano concert during the recent Mississippi Arts Festival. He is professor of surgery (otolaryngology) at the University Medical Center and a graduate of the State Academy of Music at Vienna. Mrs. Arnold, formerly a member of opera companies Flensburg, Munich, and Vienna, appeared in lyric soprano roles.

S. Lamar Bailey of Kosciusko was honored by the U. S. Selective Service for 25 years as medical adviser to the Attala County Board. He was presented a service pin and certificate of citation signed by President Johnson, Governor Williams, and Gen. Lewis Hershey. Dr. Bailey is a past president of the state medical association.

Robert H. Brumfield has been elected to serve as chief of staff in the temporary organization of the Southwest Mississippi General Hospital at McComb. Also elected were Ralph L. Brock, vice chief of staff, W. T. Mayer, secretary, J. M. Brock, chief of medicine, Marvin V. Harvey, chief of surgery, J. O. Wood, chief of radiology, Dr. Mayer, chief of general practice, Verner S. Holmes, chief of otolarynology, Wendell B. Holmes, chief of ophthalmology, and Edsel F. Stewart and Frank L. Butler, co-chiefs of obstetrics and gynecology.

Paul E. Edwards, Jr. of Columbus has announced the association of Ramon C. Lott in the general practice of medicine with offices at 109 Lawrence Drive.

William E. Godfrey of Natchez is serving as chairman for the 1968 Annual YMCA Membership Campaign. The current goal of $14,000 is the highest yet sought and an increase of $2,000 over 1967. Dr. Godfrey limits his practice at the Medical Associates Clinic to obstetrics and gynecology.

J. A. Graves of Biloxi has been re-elected president of the Gulf Coast Symphony Association, and Donald R. Rayner of Long Beach was named vice president. The symphony association anticipates a larger membership during 1968-69, plans an expansion of concert presentations, and is considering presentation of children's concerts.

Norman E. Green has announced the opening of his offices for practice at Tutwiler. He was formerly located at Clifton, Texas.

John N. Harrington of Columbus has announced the relocation of his offices in the Medical Arts Center at 221-7th Ave. North. He limits his practice to obstetrics and gynecology.

Julian T. Janes of McComb has established a scholarship to be awarded annually to a worthy high school student who matriculates at the Southwest Mississippi Junior College. Dr. Janes is secretary of the South Central Mississippi Medical

Society and a member of the state medical association's House of Delegates.

Samuel B. Johnson of Jackson has been elected chairman of the board of the Jackson Opera Guild for 1968-69. The guild anticipates a season of attractive presentations, making use of the new auditorium in the Jackson Arts Center.

Donald E. Killelea of Natchez has been named as one of five regional directors in the statewide organization of the Mississippi Association for Retarded Children.

Dewey H. Lane, Jr., of Pascagoula has been elected a member of the platform committee for the 1968 Mississippi Republican Party state convention. Dr. Lane also serves as a member of the Jackson County Executive Committee of the Mississippi Republican Party and is a delegate to the state convention.

Theodore T. Lewis of Charleston has been elected chief of staff of the Tallahatchie General Hospital. Monthly staff meetings, in addition to considering the regular business of the staff, also include scientific programs.

E. M. Meek, George J. Nassar, and Ira B. Bright of Greenwood have been named to the board of directors of the Leflore County Heart Association. Howard A. Nelson of Greenwood is serving the association as memorial gifts chairman.

Ray F. Motley of Laurel has announced the association of Anna N. Bland in practice limited to anatomical and clinical pathology at the Physicians Laboratory, 322 S. 10th Ave.

Carl G. Nichols, Jr., of Leland has occupied his new clinic building at 206 Baker Blvd. The building carries out an architectural motif of Williamsburg design, featuring a mansard roof line and cedar shingles.

Jack H. Phillips of Natchez has announced the association of J. L. Henderson in practice limited to orthopaedic surgery at the Natchez Bone and Joint Clinic on Jefferson Davis Blvd.

W. K. Purks of Vicksburg has been honored by the Mississippi Heart Association in becoming the recipient of the MHA 1968 Gold Heart Award. Dr. Purks has been a leader in the association and is a charter member. He is former chairman of the state medical association's Council on Budget and Finance.

Thomas H. Simmons of Leland has been elected 1968-69 president of the Lions Club and was installed in office during late June.

Clifford Tillman of Natchez was honored for five years service as District 1 Heart Association chairman by the Mississippi Heart Association. Dr. Tillman also serves on the state association's board of directors.

Ames Offers New Disease Detection Service

A new public service organization in the Health field, called the Disease Detection Information Bureau, has been organized here.

DDIB, which is being supported by Ames Co., of Elkhart, Indiana, will be the source for informational and educational materials in a number of different disease conditions which can be readily detected through medically-approved screening programs.

DDIB's initial task will be to serve as national headquarters for Why Wait? diabetes detection programs. Such programs are now underway in the State of Delaware, Peoria, Ill., and Jacksonville, Florida; and soon will be initiated in 13 other cities throughout the nation.

In addition, DDIB will provide support to any other community in the country which is interested in conducting a diabetes detection program. This support will include provision of a "how-to-do-it" campaign manual, and a kit which contains a wide variety of field-tested promotional materials. Supplies of certain promotional materials also will be provided to communities conducting Why Wait? programs. (Information about DDIB's services is available to any individual or organization interested in diabetes detection. Contact: DDIB, 3553 W. Peterson Ave., Chicago, Ill. 60645: (312) 267-7184.

Major emphasis will be placed by DDIB in motivating communities to conduct ongoing diabetes screening programs for high risk groups, since experience has shown that such programs are most productive of finding undetected diabetes.

However, DDIB will support shorter term programs which utilize blood testing techniques approved by the medical profession and which incorporate a system to refer positive screenees to their private physicians for diagnosis and treatment.

For communities conducting, or interested in conducting, diabetes screening programs, DDIB will serve as the national focal point—channeling to them information on results, practical problems and solutions, and other pertinent data from all other detection programs throughout the U. S.

It is estimated that, in the United States, diabetes occurs in four or more million people; yet

only two million of these people have been diagnosed as diabetics. For every known diabetic there is at least one unknown diabetic.

The Why Wait? diabetes detection program has as its goal the detection of the two million undetected diabetics. The Why Wait? theme is "Why Wait for the Symptoms of Diabetes. . . . Be Tested Now."

Diabetes is the seventh or eighth leading cause of death, and the second leading cause of blindness in the U. S. It also is a major factor of heart disease.

Diabetes is most likely to occur in certain high risk groups, including persons who are overweight, who are over age 40, who are blood relatives of diabetics and who are women who have had large (over nine pounds) babies.

The first Why Wait? ongoing diabetes detection program was launched in Delaware in June, 1967, under the sponsorship of the Delaware Diabetes Association and the Delaware State Board of Health. Some 3,614 Delaware citizens have participated in the screening program from its inception through February, 1968.

Of the 3,614 screenees, 365 were found positive on the initial screen, 168 were positive upon retesting. These 168 positives were then referred to their private physicians for diagnosis, and for treatment if such diagnosis confirmed that they were diabetics.

The second Why Wait? program was initiated in September, 1967, in Peoria, Ill., under the sponsorship of the Peoria County Medical Society and the Peoria County and City Boards of Health. From September through February 8, 1968, 1,855 Peoria residents were screened; 734 were found positive after the initial screen, 288 were positive at the secondary screen and were referred to their family physicians. Of these positives, 116 have been diagnosed as diabetic, 38 as borderline, and 82 as not diabetic.

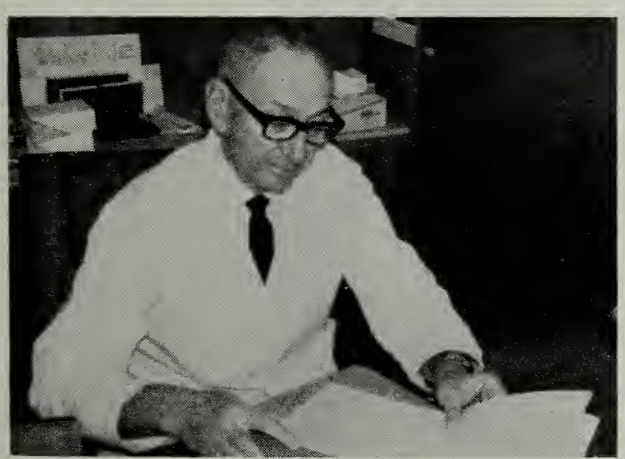
The next Why Wait? program started in Jacksonville, Fla., under the sponsorship of the Duval County Lay Diabetic Society and the County and City Health Departments. This program was initiated at the Greater Jacksonville Fair in October, 1967, and is now continuing as an ongoing activity at St. Vincent's Hospital. To date, 4,393 persons have been screened and 629 were found to be positive (to have abnormally high blood sugar). These were referred to their private doctors for retesting, diagnosis and treatment. Of this group 167 have been diagnosed as diabetic.



MSMA Maternal Care Committee Issues New Obstetrical Service Guides

The state medical association's Committee on Maternal and Child Care has provided physicians and hospitals with a new and useful professional education reference in its 10-year program to improve the quality of obstetrical care in Mississippi.

Dr. William B. Wiener of Jackson, chairman of the group which is a constitutional committee of the Council on Medical Service, said that sets of maternal health desk cards have been furnished to chiefs of staff of 128 Mississippi hospitals. The eight-card set furnishes a ready reference for keeping in hospital obstetrical suites, containing pertinent, accepted information on proper procedures, vital signs, guides for caring for obstetrical emergencies, drug usage, and a wide spectrum of factual data.



Dr. William B. Wiener, chairman of the Committee on Maternal and Child Care, examines the first set of maternal health desk cards off the press. The sets are being distributed to hospitals in the state for use in obstetrical suites.

The project of preparing, printing, and distributing the card sets was undertaken by Dr. Wiener's committee during the 1967-68 association year.

The seven-member committee consists of four obstetricians-gynecologists, an ob-gyn specialist in preventive medicine, a pediatrician, and a general practice member. Additionally, there are three consultants in anesthesiology, pathology, and internal medicine.

Currently serving with Dr. Wiener are Drs. Margaret P. Veller of Natchez, K. Ramsay O'Neal of Hattiesburg, and George J. Nassar of Greenwood, ob-gyn members; Dr. William E. Noblin, Jr., of Jackson, an obstetrician-gynecologist in preventive medicine with the State Board of Health; Dr. Wendell H. Stockton of Amory, a pediatrician; and Dr. Ralph L. Brock of McComb, the general practice member.

Consultants are Drs. Curtis W. Caine in anesthesiology, Catherine G. Goetz in pathology; and J. Manning Hudson in internal medicine, all of Jackson.

The plastic-bound desk card set, intended for keeping in obstetrical suites, consists of eight six-by-eight inch cards. Subjects covered include:

—Spinal anesthesia in obstetrics.

—Septic abortion, with or without septic shock, diagnosis and treatment.

—Oxytocics, including indications, contraindications, and administration.

—Suggested guides for prenatal care.

—Immediate postpartum hemorrhage.

—Premature separation of the normally implanted placenta, including pathology, clinical picture, and management.

—Toxemia of pregnancy, pre-eclampsia, and eclampsia, including etiology, pathophysiology, differential diagnosis, clinical course, characteristic symptoms, prevention, treatment, and postdelivery care.

—Management of the newborn, including infant resuscitation and fundamental principles of establishing normal respiration at birth.

The chairman said that the committee distributed the cards to chiefs of staff by mail with the suggestion that members of the medical staff



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but we should do something about that extra weight you're putting on."

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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with obstetrical privileges be requested to examine the card sets. A further suggestion that the obstetrical suite supervisor be given charge of the reference set was made.

Now in its 11th year, the Committee on Maternal and Child Care has a 10-year, 500-plus case series study of maternal deaths in Mississippi. These are reported annually, and selected cases are also reported for professional education value in the JOURNAL.

The committee, during 1967, coded each case in the series for data processing on the association's IBM system. Retrieval by symptomatology, clinical characteristics, para-gravida classification, cause of death, and many other avenues of access is now routinely accomplished. The committee says that the data are available for all who wish them for study, and requests for specialized printouts from the computer may be made to the association through the chairman.

Dr. Wiener plans to publish an analysis and evaluation of the 10-year study, he said. During the study over the decade, maternal mortality has declined in the state, and the committee is widely credited with contributing to the improvement of care quality.

The committee has also devoted study to perinatal mortality and hopes to initiate pilot research projects in this vital area through hospitals.

Staff work for the committee is conducted at association headquarters, and all costs of the work are borne from association dues funds. The committee conducts regular quarterly meetings.

Blood Committee Hails RhoGAM

The state medical association's Committee on Blood and Blood Banking has hailed the introduction of RhoGAM, Ortho's Rh_0 (D) immune globulin (human), as "truly a milestone in medicine."

The agent is reported to offer the opportunity of virtually eliminating erythroblastosis fetalis, Rh hemolytic disease of the new born. It has only recently become available after development and extensive clinical trial by the Ortho Pharmaceutical Corp. of Raritan, N. J.

Dr. Kenneth M. Heard of Jackson, chairman of the Committee on Blood and Blood Banking, issued the statement on behalf of his group. He said that "the development of this product is truly a milestone in medicine, and we should all feel excited over our opportunity to participate in the almost complete eradication of this specific disease."

Dr. Heard quoted Ortho spokesmen as saying that some of the same exacting procedures the laboratory follows to insure the safety of a blood transfusion must be employed with RhoGAM. Five mandatory criteria must be met:

—The mother must be Rh_0 (D) negative and D^u negative.

—The mother must not already be immunized (sensitized) to the Rh_0 (D) factor.

—Her baby must be Rh_0 (D) positive or D^u positive.

—Her baby should have a negative direct Coombs test.

—A complete crossmatch must be performed using a diluted specimen of RhoGAM crossmatched with a 5 per cent suspension of the patient's red cells.

When these five essential criteria are met, Dr. Heard said, the RhoGAM should be injected within 72 hours postpartum.

Spokesmen for Ortho told the committee chairman that RhoGAM will be distributed only through hospital laboratories because of the key role played by the laboratory in the proper employment of the agent. Dr. Heard said that a question has arisen among members of the committee as to distribution to laboratories in smaller hospitals which are not directly supervised by an attending pathologist or hematologist. Most such small hospitals, he said, have consultative arrangements with either an independent physician-supervised laboratory or with a pathologist from a larger hospital.

Ortho spokesmen said that distribution of the agent on a limited basis will be made to small hospital laboratories, and "limited" was defined to mean one dosage unit in stock. Because of supply limitations, the single unit reserve will be considered "adequate stock."

The statement assured availability of RhoGAM, however, regardless of the size of the hospital, through a loan arrangement with larger institutions. Such arrangements will be managed by Ortho representatives in the area.

Dr. Heard said that the committee has discovered from its previous studies that the level of application of immuno-hematological procedures is rather low in some small hospitals, and he noted the view of Ortho as "somewhat optimistic that anyone who gives a blood transfusion should be able to determine as to whether or not the criteria have been fulfilled."

Dr. Heard said that the Committee on Blood and Blood Banking urges that "the hospital not having an attending hematologist or pathologist obtain consultation with and approval of their consulting hematologist or pathologist before a dose of RhoGAM is administered." He said that the 72 hour period should allow adequate time for this.

The committee's statement pointed out a non-medical reason for judicious use of the product: The price per dose is $64.80.

Association spokesmen said that an inquiry has been directed to the Department of Defense as to procedures for reimbursing costs of the agent when employed with patients under the CHAMPUS program. Laboratory procedures necessary to establish that the patient meets the five essential criteria are already authorized when ordered by the attending physician.

DEATHS

BOWMAN, CHARLES RALPH, M.D., Medical College of Virginia, 1928; Commander, U. S. Navy Medical Corps, World War II. Practiced in North Carolina, locating at Jackson in 1946. Chairman of the corporation, Jackson Coca-Cola Bottling Co.; died May 25, 1968, aged 67.

CALDWELL, REUBEN BERMIS, Baldwyn. M.D., Memphis Hospital Medical College (University of Tennessee), 1913; interned St. Joseph's Hospital, Memphis; additional postgraduate study at the Tulane University School of Medicine, New Orleans. Member, Mississippi State Board of Health, 1944-62; president of State Board of Health, 1947-62. Pioneer in Mississippi Hill-Burton hospital construction program; president, Mississippi State Medical Association, 1948; president, Mid-South Postgraduate Medical Assembly. Emeritus member, Mississippi State Medical Association; member, Fifty Year Club. Died May 7, 1968, aged 82.

DANIEL, WILLIAM JACKSON, JR., Fulton. M.D., University of Tennessee College of Medicine, Memphis, 1946; interned John Gaston Hospital, Memphis, one year. U. S. Army Medical Corps, 1948-50. Died June 2, 1968, aged 55.

ROGERS, OSBORN BRITAIN, Como. M.D., Vanderbilt University School of Medicine, Nashville, Tenn., 1909. U. S. Army Medical Corps, World War I. Died May 13, 1968, aged 82.

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UMC Graduates 102 in 12th Commencement

The University of Mississippi School of Medicine awarded 102 graduate degrees in the health and life sciences at its 12th annual commencement on June 2. Sixty-five students received the M.D. degree, and 19 candidates were awarded degrees in nursing. The Ph.D. was given to 11 graduate students, and seven received the M.S. in health sciences.

Dr. E. R. Jobe, retiring executive secretary of the Board of Trustees of Institutions of Higher Learning, was the commencement speaker, addressing the graduates on the purposes of education.

Activities for the occasion began with a breakfast for the graduates and their families followed in the early afternoon with the traditional Chancellor's reception at which Dr. and Mrs. Porter Fortune were hosts.

Among the M.D. graduates, Jackson led the state with 14, the remainder being representative of all areas of the state. One graduate was from Louisiana and one, from New York.

Thoracic Society Conducts Annual Meet

The Mississippi Thoracic Society, the medical arm of the Mississippi Tuberculosis Association, held its 168 annual meeting Thursday at the University Medical Center in Jackson, with over 100 physicians attending.

During the business session, officers were elected for the coming year. They include Dr. Myra Tyler of Jackson, president; Dr. Joe S. Covington of Meridian, vice president; Dr. Helen Bernfield of Jackson, secretary-treasurer; Dr. Al Meena of Jackson, and Dr. Fred Tatum of Hattiesburg, Executive Committee members; Dr. John Busey of Jackson, ATS Council member; and Dr. G. Boyd Shaw of Jackson, Tri-State Conference program representative.

The program was opened by Dr. Dwight Keady, vice president of the Mississippi Thoracic Society of Sanatorium, and Dr. Robert E. Carter, dean of the University Medical Center at Jackson, who welcomed society members.



Mississippi Thoracic Society officers discuss the recent annual meeting. They are, from left, Drs. Boyd Shaw of Jackson, program chairman; Dwight S. Keady of Sanatorium, retiring president; Helen C. Bernfield of Jackson, secretary-treasurer; and Frederick E. Tatum of Hattiesburg, member of the executive committee.

The scientific program conducted at the University of Mississippi Center featured as guest lecturers Dr. Ben Branscomb of Birmingham and Dr. Milton V. Davis of Dallas.

Dr. Branscomb presented papers on "Current Approach to the Management of Chronic Obstructive Pulmonary Disease" and "Recent Developments in Management of Acute Respiratory Failure."

Dr. Davis presented a paper on "Recurrent Bronchitis and Pneumonitis in Children Associated with Gastroesophageal Reflux."

The annual meeting program included: selected case presentations on "Occupational Respiratory Diseases in Mississippi" including "Byssinosis," by Dr. Bob Robinson of Jackson; "Silo-Fillers Disease" by Dr. H. Karl Stauss of Jackson, and "Silicosis," by Dr. John Morgan of Jackson.

Dr. Hilary Timmis of Jackson presided at the Surgical Grand Rounds featuring "Current Methods of Management of Selected Types of Chest Trauma."

To complete the meeting, selected case presentations on "Interesting Pulmonary Problems" were presented by Dr. Dewey Lane of Pascagoula; Dr. Henry Tyler of Jackson; Dr. Antone Tannehill of Tupelo; and Dr. G. Boyd Shaw of Jackson.

Lilly Reduces Price of V-Cillin K

Wholesale prices of all capsules and tablets containing forms of a widely used oral penicillin—phenoxymethyl penicillin—were reduced by Eli Lilly and Company in a range from 10 to 22½ per cent, effective June 3. It is the fifth Lilly price cut for this antibiotic in eight years.

Phenoxymethyl penicillin is made available under the trademark V-Cillin; and its potassium salt, under the trademark V-Cillin K.

The Lilly company said the largest price cut applies to the most popular tablet sizes and packages. These tablets are now less than one-third of their 1959 prices.

For example, the five reductions for V-Cillin K tablets in packages of 100's of the 125 mg. and 250 mg. strengths have been as follows: 25 per cent in 1960, 15 per cent in 1962, 21½ per cent in 1965, 20 per cent in 1967, and 22½ per cent in 1968.

Prices of the pediatric forms of phenoxymethyl penicillin, which were reduced 10 per cent last year, remain the same.

A company spokesman said the experience with V-Cillin follows the normal Lilly practice of reducing prices of products as developmental research achieves savings in their production costs.

The spokesman emphasized that developmental studies are concerned with improving the product just as much as in increasing yields. The latest improvement of the V-Cillin K tablets was the addition of an Identi-Code® symbol on each tab-

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Association's HIBAC Is New Advisory Body

The Health Insurance Benefits Advisory Committee of the state medical association has been formally designated as the official advisory body to the State Board of Health in its role as certifying agency to Medicare providers. The committee is an *ad hoc* body of the Council on Medical Service.

Dr. Mal S. Riddell, Jr., of Winona, a member of the Board of Trustees, chairs the committee. Members include Drs. Kenneth M. Heard, Elmer J. Harris, and W. Couprey Shands of Jackson, Thomas F. Puckett of Hattiesburg, Joe S. Covington of Meridian, Alton B. Cobb, and Robert D. Currier, both of Jackson.

Meeting with the group recently were officials of the State Board of Health, including Harold Whittaker. Mr. Whittaker is supervisor of the



Bryce McMahan of Hattiesburg, left, president of the Mississippi Nursing Home Association, confers with the association's HIBAC chairman, Dr. Mal S. Riddell, Jr., at the recent Jackson meeting.

Health Insurance Unit. Other advisers and consultants met with the committee.

Also conferring with Dr. Riddell's group were representatives of the Traveler Insurance Co., Part 1-B carrier for Medicare in Mississippi; the Mississippi Hospital and Medical Service, Inc., Part 1-A hospital fiscal intermediary; and Mutual of Omaha, fiscal administrator for nursing home services.

MHA Names Dr. Tatum as 1968-69 President

Dr. J. P. Tatum of Meridian was inaugurated 1968-69 president of the Mississippi Heart Association at its recent Jackson annual meeting. He succeeds Rep. G. V. (Sonny) Montgomery of Meridian who served during the past year.

Named also to top officer spots are Donald Bartlett of Como, president-elect; Dr. G. Spencer Barnes of Columbus, vice president; Ernest G. Spivey of Jackson, secretary; and Ray R. McCullen of Jackson, treasurer.

Special honors were conferred by the association upon Dr. W. K. Purks of Vicksburg, Dr. James H. Hardy of Jackson, professor and chairman of the Department of Surgery at the University Medical Center, and Mr. Spivey.

Congressman Montgomery, in his presidential address, said that the heart association has invested more than $600,000 in the research work of 78 Mississippi scientists during the past 15 years.

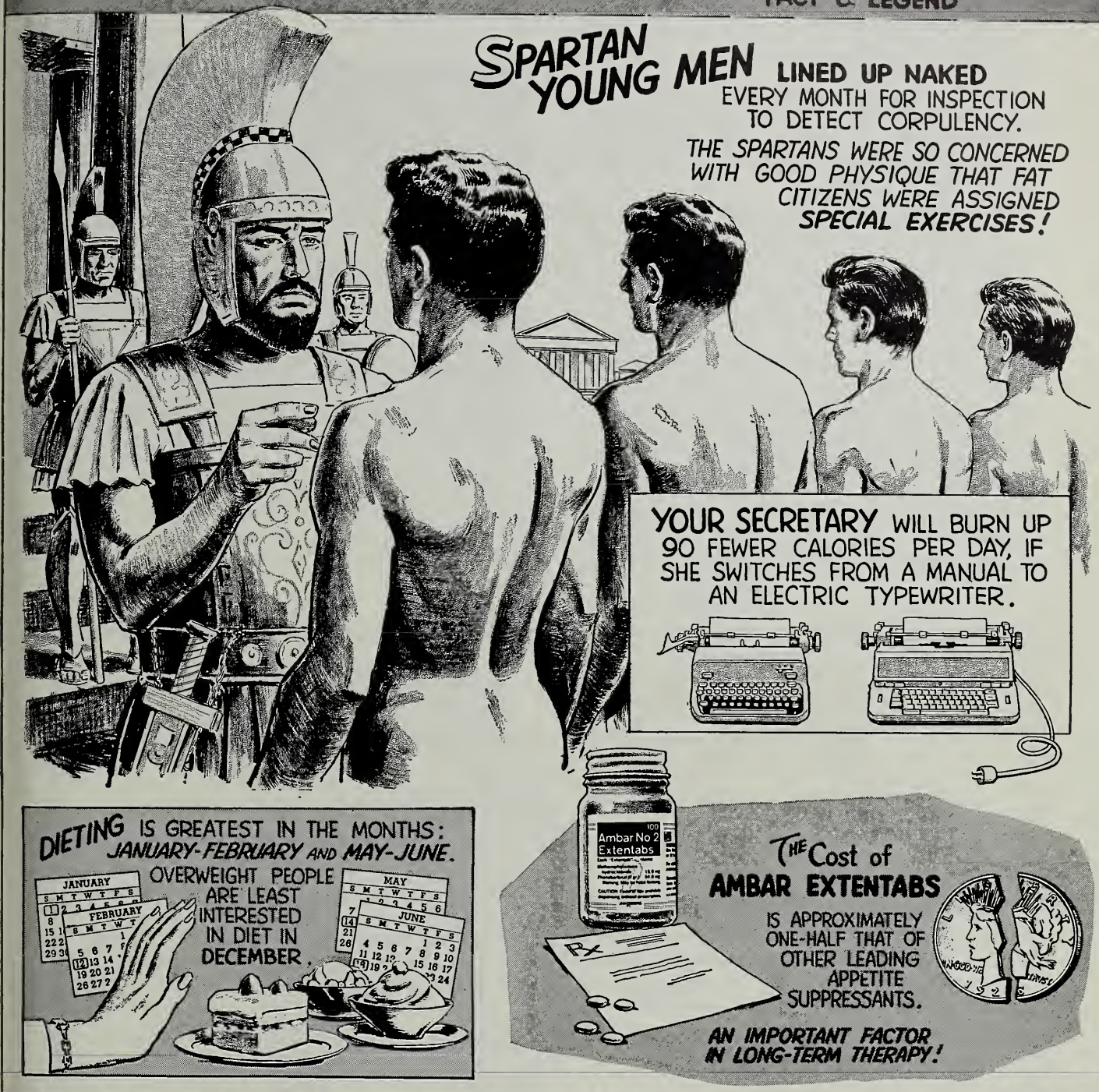
AMA Will Sponsor Sports Medicine Meet

The 10th National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Miami Beach, Florida, at the Hotel Deauville on December 1, 1968. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

As was true of the previous nine Conferences, the 10th will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums on the management of knee injuries, back problems, and problems related to vision in sports. Other sessions will be devoted to a series of clinical concerns in sports warranting increased attention (e.g., cauliflower ear, pulled muscles, facial injuries, and communicable disease). One discussion session will be devoted to the controversial issues affecting participation of young athletes, another to health and safety considerations in the conduct of aquatic activities.

The featured luncheon speaker will be Payton Jordan, Head Coach of the 1968 U. S. Olympic Track and Field Team, who will discuss "The Olympics in Retrospect."

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One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

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ORGANIZATION / Continued

Tuberculosis Association Names New Leaders

The Mississippi Tuberculosis Association conducted its annual meeting at Jackson where Dr. Guy Campbell, chief, pulmonary disease section, V.A. Hospital, of Jackson, ended a successful two years as president.

Mrs. Cecil C. Fox of Canton was elected president by volunteers from the 87 county tuberculosis associations. The mid-day meeting featured sessions of the association's plans to provide funds for a Professor of Pulmonary Diseases at the University Medical Center, "Memorials and Bequests and other supplementary Fund-Raising," a talk on "Christmas Seals Around the World," and health education projects for the coming year.

Medical members serving on the board of directors of the association include Dr. Clyde Watkins of Sanatorium; Dr. Robert Schwartz of Hattiesburg; Dr. A. N. Morphy of Gulfport; Dr. Frank Morgan of Jackson; Dr. Durward Blakey of Jackson; and Dr. Marian Godbey of Aberdeen.

Ole Miss Students Visit Warner-Chilcott



Fifty-five pharmacy seniors from Ole Miss recently visited the manufacturing facilities of Warner-Chilcott at Morris Plains, N. J. Here, Jerome Genzer, chief of the process division, demonstrates chemical production techniques to interested students.

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Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

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Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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New Program Offers Specialty Services

A new and additional approach to postgraduate education has been instituted under University Medical Center auspices. The concept involves a "specialist of the day," physicians in various disciplines who will visit hospitals throughout the state for one-day intensive consideration of appropriate subjects.

Dr. Robert Currier, associate professor of medicine and chief of the division of neurology, was specialist of the day at Singing River Hospital June 3 in Pascagoula. Programs have already been given in Pascagoula by Dr. William O. Barnett, professor of surgery, and in Clarksdale by Dr. John Bower, assistant professor of medicine and director of the artificial kidney unit.

Dr. Davis Is Listed Among Civic Leaders

Dr. Frank M. Davis of Corinth, former vice president of the Mississippi State Medical Association and incumbent member of the Council on Legislation and a director of MPAC, has been named in the 1968 Directory of Outstanding Civic Leaders of America.

The listing is in recognition of Dr. Davis' contributions in civic work in his community and state. He is a former recipient of the MSMA-Robins Award and has served in many civic capacities, including that of vice president of the Tennessee-Tombigbee Waterway Development Authority.

Dr. Davis is a native of Booneville and a medical graduate of Vanderbilt. He is president of the Corinth Broadcasting Co. and a director in the National Bank of Commerce.

Louisiana Society Chief Dies in Office

The 1968-69 president of the Louisiana State Medical Society, Dr. Nicholas J. Chetta of New Orleans, died within the month of his inauguration. He served only 23 days in office.

The late president was graduated from the Louisiana State University School of Medicine in 1941.

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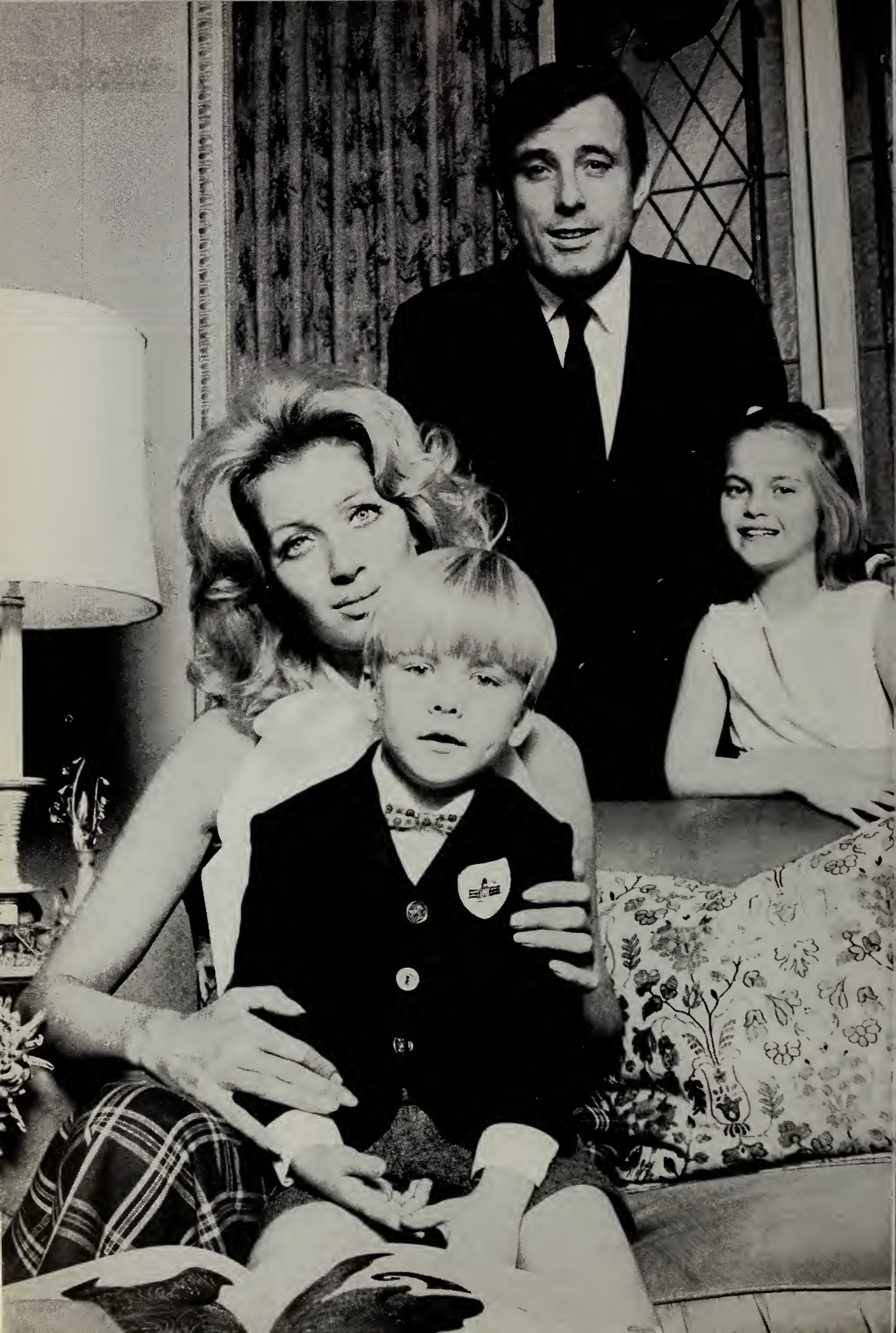
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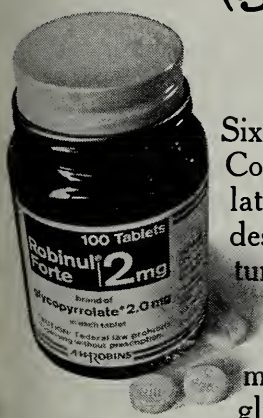
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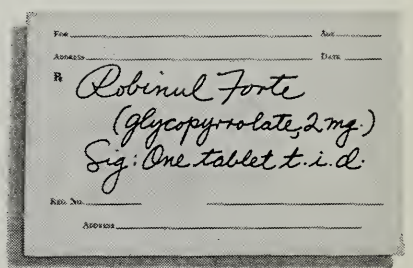
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Vitamin B_6	7.5 mg
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AHA Urges Extension of Regional Programs

Congress can make "a very positive contribution" toward improving the health of Americans by extending Public Law 89-239—the Regional Medical Programs act—for another five years. the American Hospital Association said.

The association, which represents nearly 7,000 hospitals, said in an editorial in the *Journal of the American Hospital Association,* that existing regional medical programs provide evidence that the health care objectives of PL 89-239 are being realized.

Congress is now considering the Administration's request for a five-year extension of the law. and is expected to act on the measure before adjourning.

"If the extension is approved," the editorial said, "it will be a tribute to the current achievements of regional medical programs and, more significantly, a very positive contribution toward the improved health of our nation."

The editorial also urged hospitals to "recognize and respond" to their responsibility to participate in the planning and implementation of regional medical programs.

It pointed out that RMPs represent "an evolutionary partnership" of the federal government. hospitals, physicians, and others to combat heart disease, cancer, stroke, and related diseases. These diseases are responsible for 70 per cent of all deaths in the United States.

"A hospital is the logical focal point of projects and developments of regional medical program activity," the editorial declared, "since it is the dispenser of program achievements to the patient."

Regionalization enables individual hospitals to benefit from health care research and facilities they lack but that exist elsewhere in their region. the editorial said. Regional programs can provide special training at major medical centers for medical and paramedical personnel who, in turn, can communicate their knowledge to their colleagues in community hospitals.

The editorial acknowledged that it is difficult to coordinate the leadership and manpower necessary to achieve the intent of PL 89-239.

"Voluntary hospital administrators, trustees. and physicians are often prejudiced against federal participation in health care planning and practice," the editorial said. "But regional medical programs are overcoming these biases and limitations . . . and the programs are becoming viable. concerted efforts toward the achievement of their goals."

Seminars Are Set for Heart Session

Five all-day postgraduate seminars on various aspects of cardiovascular disease will be held in conjunction with the American Heart Association's annual Scientific Sessions next November in Bal Harbour, Fla.

Under sponsorship of five of the Association's nine scientific Councils, the seminars are set for Wednesday, Nov. 20 in the Americana Hotel. The AHA scientific program runs from Thursday through Sunday, Nov. 21-24, also in the Americana.

Intended primarily for members of the Councils, the seminars have been planned to be of equal interest to physicians and scientists generally.

The sponsoring Councils and their seminars are:

Council on Rheumatic Fever and Congenital Heart Disease: "Cardiovascular Problems of the Adolescent and Young Adult with Congenital Heart Disease." Will present long-term studies of some common types of congenital heart disease with particular stress on analysis of serial cardiac catheterization data obtained over a number of years. Hemodynamic data and exercise studies of post-operative patients, recent studies of sudden death in the infant and young adult, and the management and prognosis of the young adult with congenital heart disease, will be discussed.

Council for High Blood Pressure Research: "Antihypertensive Drug Therapy." Intended to survey the status of current antihypertensive drug armamentarium. Some special treatment problems will be discussed and the effect on morbidity and mortality will be reviewed.

Council on Circulation: "Neural and Humoral Mechanisms of Peripheral Vasodilatation." Designed to review for the cardiologist the complex mechanisms involved in relaxation of vascular smooth muscle. The sequence of events within the smooth muscle cell will be described and the way in which these events are altered by vasodilatator nerves, acetylcholine, kinins, adenine nucleotides and other chemical agents will be reviewed.

Council on Basic Science: "Cardiovascular Mechanics: Definition of Terminology and Problems —A Report on 1968 Summer Workshop." Jointly sponsored by the National Aeronautics and Space Administration, the seminar will be based on a summer workshop scheduled on the topic. Although open to all individuals, the seminar is particularly intended for the young investigator with an interest in this topic.



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Syntex Expands to Health Care Field

Syntex Laboratories, Inc. will pursue a program to develop new business activities in the broad field of health care, including diagnostics. This new program will be under the leadership of Syntex Laboratories Vice President Paul O. Bancroft, it was announced today by Dr. Albert Bowers, president.

Dr. Bowers further stated that the company would develop new business opportunities through a multi-faceted approach including company and product acquisitions.

Mr. Bancroft joined Syntex Laboratories in September 1960 when the parent company decided to organize a marketing subsidiary in the United States. He played a key role in developing Syntex Laboratories into a major U. S. pharmaceutical company nationally known for its birth control and anti-inflammatory products.

Mr. Bancroft has been serving as vice president for Marketing and general manager of the Pharmaceutical Division. He joined the company as advertising manager in 1960 and was promoted to director of Marketing in 1962. He was appointed vice president for Marketing in 1964 and added the title of general manager of the Pharmaceutical Division in 1966.

He is a graduate of Norwich University and has been director of the National Pharmaceutical Council for the past four years.

New Manual Is Out on Resuscitation

A new manual to assist hospitals in planning, organizing and implementing programs for administering emergency cardiopulmonary resuscitation (CPR) has been issued by the American Heart Association and its nationwide affiliates.

Entitled "Emergency Resuscitation Team Manual: A Hospital Plan," the 56-page booklet stresses that "it is the responsibility of every hospital, regardless of size to have an effective program for emergency resuscitation," and that the planning for such a program deserves the highest priority.

The manual covers all phases of a hospital CPR program, from the initial organization of a CPR Committee and an outline of its duties through to the aftercare of patients who have been resuscitated. Sections are devoted to training programs for hospital staff and ambulance personnel and

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rescue squads who use its emergency services; communication (alert) systems for rapid mobilization of CPR personnel; and the movement of personnel and equipment in CPR emergencies.

Prepared by the American Heart Association's Committee on Cardiopulmonary Resuscitation, the publication's recommendations are based on currently approved standards and techniques. Alternate plans are suggested for adaptation to the hospital's size and needs.

Copies of the manual may be obtained by hospitals, medical schools, medical societies and through Heart Associations in their communities.

Indiana Life Carrier Covers Retarded

The traditional attitude of insurance underwriters toward the mentally retarded will be subject to review and reconsideration following the announcement by an Indianapolis-based insurance company that it is prepared to offer life insurance to the retarded "under extremely liberal conditions, at the same standard rates as for the non-retarded."

Institutional Life Insurance Company, a stock company organized in 1966 "to work in close cooperation with health, educational and charitable organizations," has announced to associations for retarded children throughout the country that it will offer its 20 Pay Endowment At 65 policy to retarded persons.

Thomas F. Cairns, president of Institutional Life, said that detailed actuarial studies and recent medical and scientific developments in the field of mental retardation led his company to this decision.

"Medical research is making valuable contributions which aid in the diagnosis and treatment of mental retardation," Cairns said. He added that the attitude of the general public and of educators is more and more being directed toward rehabilitation and special education than toward custodial care. Cairns explained that, whereas there had been several studies concerning the mentally retarded who are being cared for in institutions, "there could be found no impairment studies of the retarded among the general public which would lead to the conclusion that mental retardation has any significant effect upon life expectancy."

Nearly a year ago, Institutional Life "broke" with insurance tradition when it announced plans to issue life insurance on epileptics.

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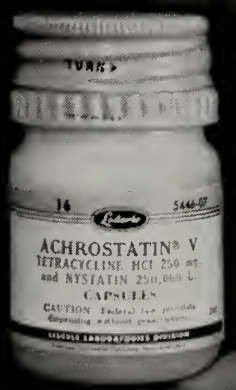
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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

August 1968

Dear Doctor:

The University Medical Center's continuing education program for physicians has been accredited by the AMA Council on Medical Education. The landmark approval puts UMC in top 20 per cent of all major medical centers in U.S. and opens the door to full development of postgraduate medical education as recommended by House of Delegates last May.

> As of first surveys for PG program accreditation last September, only 14 institutions received approval. AMA officials have congratulated UMC on being among the first to receive approval accolade. Listing will appear in Aug. 5 JAMA.

Colorado Medical Society has given new medical nomenclature to an old disease, calling 21 hospital admissions at Denver "hippie hepatitis." All of the patients, unwashed members of bangles, beads, sandals, and sweatshirt subculture, admitted self-administration of methamphetamine parenterally, passing the unsterilized syringe around at a "tea party."

AMA's Board of Trustees, taking a cue from the successful Millis Commission, has named a nine-member advisory body of distinguished laymen. New group will study and advise on present and future health needs of the American people. Chaired by Dr. Charles E. Odegaard, a historian and president of University of Washington, group includes such members as Charles Shuman of Farm Bureau and Kermit Gordon, president of Brookings Institution.

Public utilization of hospital outpatient departments has reached a new high nationally, according to American Hospital Association. AHA reports that 9.5 million visits were recorded during April, a gain of 10 per cent over April 1967. Data also show that a typical hospital serves between 2.5 and 5.5 outpatients for each single inpatient admission.

Travelers Insurance reports slight and predictable decrease in monthly claims volume in Mississippi for June, handling 16,650 Part 1-B claims. Payments to physicians totaled over $707,000, down about $90,000 from May. Assignment ratio holds steady with 13 out of 20 claims from physicians taking assignments.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

FDA Finds Brand Drugs Outperform Generics

Washington - Dr. Herbert L. Ley, Jr., new FDA commissioner, indicates that his agency is "rethinking" the concept that generic drugs are just as good as brand names. FDA announced that in human tests, two antibiotics and a sulfa were less effective in generic than in brand-name dosage forms. One FDA source was quoted as saying that the Pharmaceutical Manufacturers Association was "more right than we gave them credit for." MSMA opposes compulsory generic prescribing, supporting freedom of drug choice for physicians.

JCAH Announces Extern Policy

Chicago - The Joint Commission on Accreditation of Hospitals says that unsupervised examination of patients and history-taking by a medical student is "not conducive to the best quality of medical care" and that it isn't an educational experience, either. Although refraining from evaluating training programs, JCAH will henceforth require evidence of supervision of externs and certification and approval by the dean of the medical school in which the student is enrolled.

New York Court Denies Chiropractic Claim

Albany, N.Y. - A New York appellate court, despite the state's having legalized the cult of chiropractic, denied a plaintiff's claim against an insurance company which had refused to pay for chiropractic services, reversing a trial court decision in favor of the plaintiff. At new trial, the testimony of the chiropractor himself that his services were medically necessary was held to be incompetent. Citation is Suris v. Government Employees Insurance Co., 278 N.Y. 2d (N.Y., Feb. 15, 1967).

Cancer Registry Is Hailed As Successful

Salt Lake City, Utah - The Intermountain Regional Medical Program, covering Utah, Idaho, Montana, Colorado, Nevada, and Wyoming with a cancer registry program, is furnishing a "functional weapon against cancer and not just a list of incidences and death rates." New registry is helping physicians identify occurrence and types of tumors and to evaluate effectiveness of treatment given.

HII Suggests Health Coverage Minimums

New York - The Health Insurance Institute, major association representing most health insurance carriers, urges that at least 70 days of inpatient care benefits be purchased in any contract. HII also recommends that sufficient surgical benefits be provided to meet costs of new and improved techniques.

HEW-AAMC Agree on Study

A contract in the amount of $71,240 between the Department of Health, Education and Welfare and the Council of Teaching Hospitals of the Association of American Medical Colleges, to study the feasibility of establishing a teaching hospital information center, has been announced by Dr. Robert C. Berson, executive director of the Association of American Medical Colleges and Matthew F. McNulty, Jr., director of the Council of Teaching Hospitals and Associate Director of the AAMC.

The study will be conducted by the Council of Teaching Hospitals. The sponsoring agency for the study within the Bureau of Health Services is the office of Research and Development. Dr. Thomas McCarthy will serve as project officer.

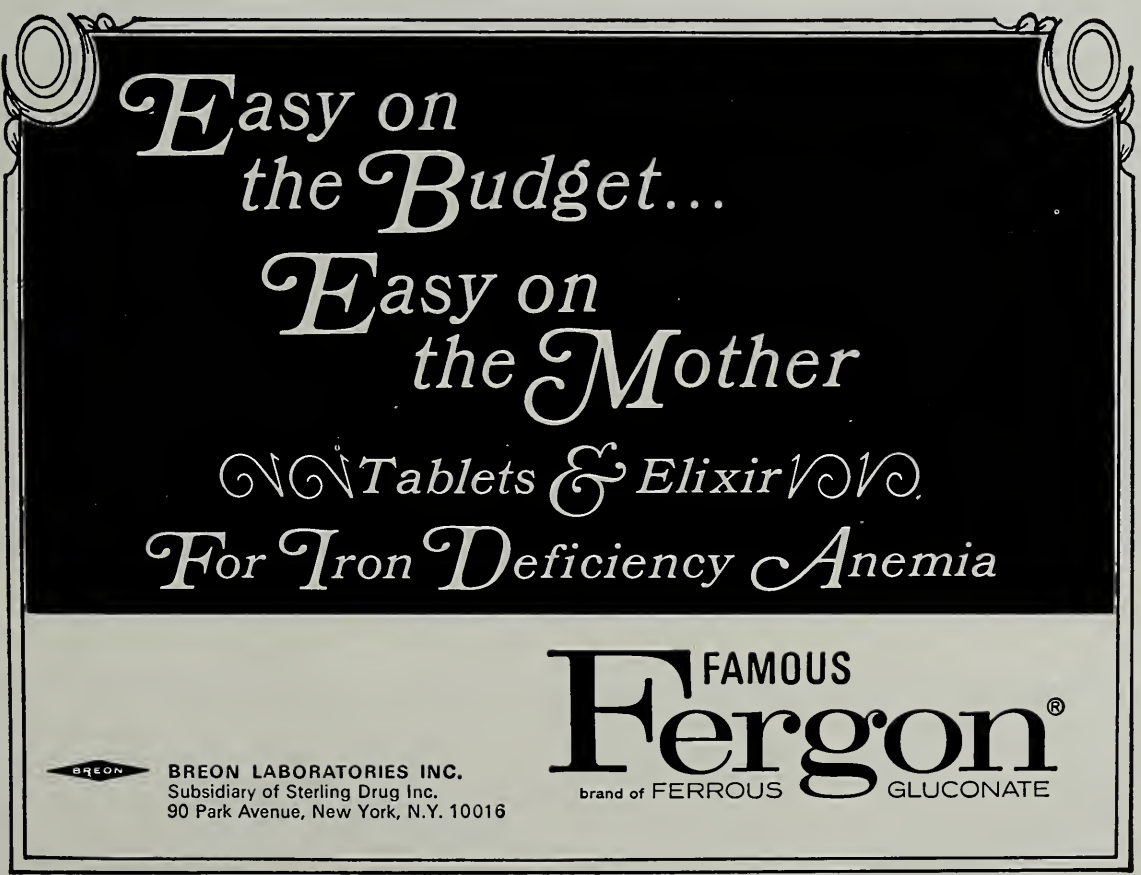
In commenting on the nature of the study, McNulty noted, ". . . one of the most significant features of this activity will be the development of a methodology designed specifically for the dissemination of a constantly changing body of information of particular interest to those involved in the administration of teaching hospitals."

Additionally, the Council will study ways to encourage innovation and experimentation, and to evaluate present administrative stimuli to continued research on relationships between teaching hospitals and medical schools or medical centers.

Candidates are presently being evaluated for the position of project director for the study. The Council as well as the project director and other staff for the project, will work closely with the new National Center for Health Services Research and Development and other interested agencies both governmental and voluntary, which have displayed an interest in teaching hospitals.

It is the experience of the Council and the AAMC that an interrelationship between the public and private sector can provide an increased awareness of the uniquely qualified teaching hospital as a social institution while also increasing for society the contribution by teaching hospitals as a result of expanded knowledge and awareness of those responsible for institutional executive leadership.

The location for the study will be in the headquarters office of the Council of Teaching Hospitals at 1346 Connecticut Avenue, N.W. in the Washington office of the AAMC. Dr. Fletcher H. Bingham is Assistant Director of the Council for the areas of research, development and education.





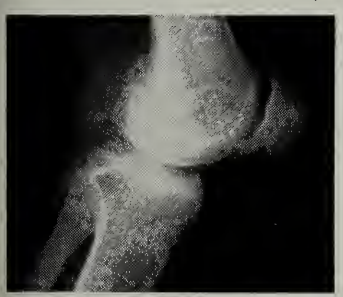
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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

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vate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

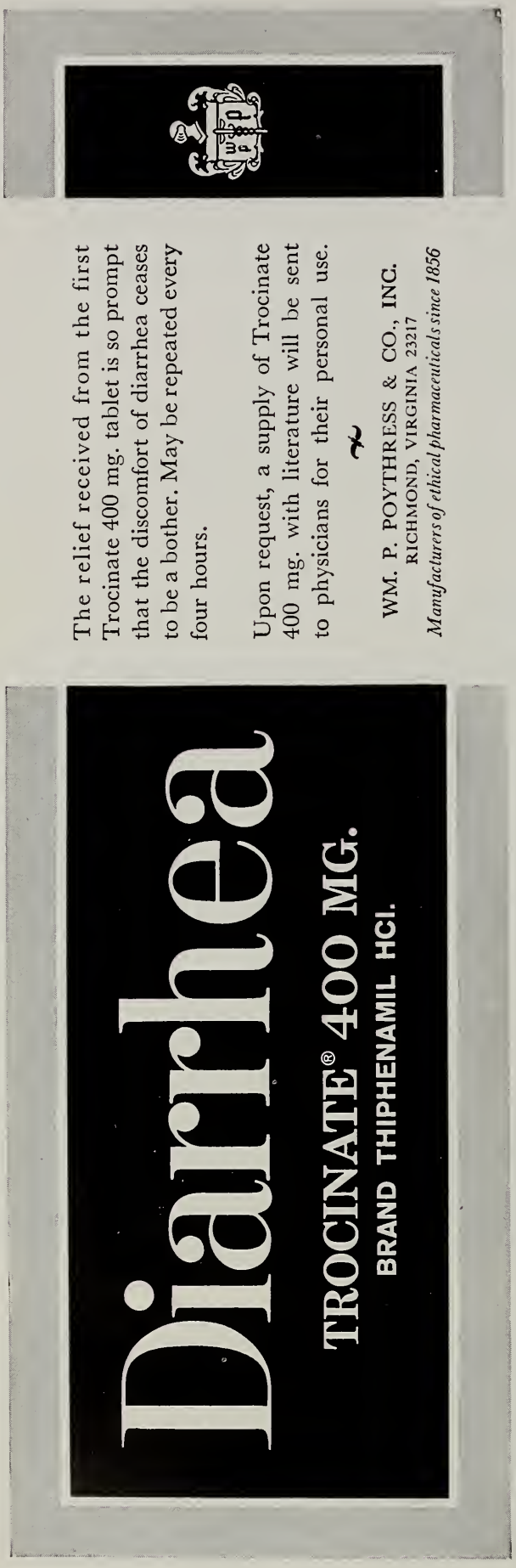
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AMA Schedules Congress on Quackery

The Fourth National Congress on Health Quackery will be held at Chicago October 2-3 at the Drake Hotel.

Joint announcement of the Congress was made by Dr. F. J. L. Blasingame, executive vice-president of the American Medical Association, and Peter G. Meek, executive director of the National Health Council.

"Protecting the Consumer" will be the theme of the meeting.

"Health quacks bilk the American public of hundreds of millions of dollars every year," said Dr. Blasingame. "Their nostrums, health foods, and 'miracle cures' are not only frauds but frequently harm the patient by giving him the illusion that he is under medical treatment. The American Medical Association regards its continuing battle against quackery as one of its most important activities."

The Quackery Congress will be the opening event of "AMA Law Week," October 2-6. The Law Week program, also to be held at the Drake Hotel, is to include the Second National Congress on Medical Ethics and the biennial Legal Conference for Medical Society Representatives.

The National Health Council, co-sponsor of the Congress with the AMA, is the nation's largest organization of professional, governmental and voluntary agencies in the health field. They also co-sponsored the last previous Quackery Congress, held in 1966 in Chicago. Two earlier Congresses, in 1961 and 1963, were held in Washington, D. C.

About 500 to 600 persons representing medicine and allied health professions, government. and voluntary health organizations are expected to attend. Attendance will be by invitation.

Details, including the program of speakers, will be announced later. Inquiries should be addressed to: Dr. Joseph A. Sabatier, Jr., Chairman, Committee on Quackery, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

New NCI Editor Is Appointed

Dr. Mearl F. Stanton of the Laboratory of Pathology, National Cancer Institute, has been appointed Scientific Editor of the *Journal of the National Cancer Institute* by Dr. Kenneth M. En-

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
August 1968, Vol. IX, No. 8

ORIGINAL PAPERS

Retroperitoneal Cysts: Review of 32 Cases

JACKSON R. GALLOWAY, M.D., and
JAMES T. PRIESTLEY, M.D.
Natchez, Mississippi, and Rochester, Minnesota

The records of all patients who had surgical treatment for retroperitoneal cyst at the Mayo Clinic from 1935 to 1964 were reviewed. Out of the total of 32 cases, 20 patients were females and 12 males. Most of the patients had nonspecific symptoms referable to the cyst; pain and abdominal mass were the most frequent symptoms. The authors report the findings of the study and review the literature.

HANDFIELD-JONES[4] in 1924 defined primary retroperitoneal cysts as "those cysts lying in the retroperitoneal fatty tissues which have no apparent connections with any adult anatomical structure save by areolar tissue." Primary retroperitoneal cysts are rare. Pack and Tabah[13] reported that only five such lesions were encountered in 120 patients who had retroperitoneal tumors. Cysts of this type are benign and slow growing and make their presence known only by the effects of pressure on adjacent structures.

The site of origin of primary retroperitoneal cysts is variable. Some cysts may arise from embryologic remnants of the wolffian or müllerian ducts.[9] It has also been suggested that small islands of tissue from which the posterior peritoneum arises may persist and later give rise to cyst formation.[4] Cysts of lymphatic origin may result from a developmental abnormality, obstruction, or neoplastic change. Retroperitoneal cysts of traumatic origin may result from incomplete resolution of hematomas. Retroperitoneal cysts of parasitic origin have also been reported[4] but are not included in this report.

A number of authors[1-3, 5-17] have contributed to the literature of retroperitoneal cysts. Complete surgical removal is advocated as the treatment of choice. The value of a plain roentgenogram of the abdomen and, particularly, intravenous urography is stressed as important in preoperative study of the patient. In addition to demonstrating possible encroachment on a ureter or kidney, urography will indicate the condition of the opposite kidney should nephrectomy be necessary. Urography also is helpful in determining the location of the cyst as being retroperitoneal if there is displacement of a kidney or ureter.

The records of all patients who had surgical treatment for retroperitoneal cyst at the Mayo Clinic from 1935 to 1964 were reviewed. By definition, patients who had mesenteric or omental cysts or cysts of renal, adrenal, ovarian, pancre-

From the Section of Surgery, Mayo Clinic and Mayo Foundation and the Mayo Graduate School of Medicine, University of Minnesota.

atic, or other recognizable origin are not included in this study, nor are those with dermoid cysts[17] or degenerating cystic retroperitoneal neoplasms. The resulting group comprised 32 patients.

In this group of 32 patients, there were more females (61 per cent) than males. The youngest patient was 4½ years old and the oldest 65 years old. Most patients were between the ages of 21 and 60 years, with the largest number being in the fifth decade.

Twenty-eight of the 32 patients (87 per cent) had some type of symptoms referable to the cyst, whereas the remaining four had no symptoms. In the asymptomatic group, an abdominal mass was discovered during a routine physical examination or one performed for unrelated complaints. Approximately half of those who had symptoms sought medical attention within six months after the onset of symptoms, although two patients had been aware of an abdominal mass for as long as eight years before consulting a physician. Symptoms, when present, were nonspecific. The two most frequently noted were pain (15 patients) and an abdominal mass (7 patients). Loss of weight, bloating, belching, abdominal distention, or swelling occurred next in order of frequency, and a few patients had nausea and vomiting.

Physical examination revealed that 27 patients (84 per cent) had a palpable abdominal mass. In approximately one-fourth of these patients the mass was tender, and in about one-half it was movable. Terms used to describe the size of the mass, such as "grapefruit," "watermelon," and "baby's head," indicated that it was large in virtually all patients, although in a few it was much smaller and was discovered only at laparotomy performed for some other condition.

X-RAY EXAMINATION

Roentgenologic examination was the most helpful diagnostic procedure (Table 1). A plain roentgenogram of the abdomen indicated or revealed the presence of a mass in two-thirds of the patients in whom it was taken. In three-fourths of the patients in whom an excretory urogram was made, a significant abnormality was noted. Studies of the colon with use of barium revealed information of diagnostic value in approximately half of the patients in whom they were made.

TABLE 1

ROENTGENOLOGIC EXAMINATION OF 32 PATIENTS WITH RETROPERITONEAL CYSTS

Type of examination	*No. of patients*	*Abnormal findings*
Plain roentgenogram of abdomen	29	18
Excretory urogram	24	18
Colon	21	10
Stomach	4	1

SURGICAL EXPLORATION

Abdominal exploration was performed in all 32 patients. In several patients the presence of a cyst was not known prior to an operation that was performed primarily for some other condition. The cyst was removed completely in 29 patients and subtotally in another patient. Incision and drainage only was preformed in two patients. In one patient in whom the cyst was removed, nephrectomy also was performed, and in another a portion of the colon was resected. At operation, cysts were found to be located with equal frequency on the right and left sides of the abdomen. Five cysts were described as being "mid-abdominal" in location, two as pelvic, and one as virtually occupying the entire abdominal cavity. There was one postoperative death (1945) related primarily to a saddle type of thrombosis that occurred at the bifurcation of the aorta and extended proximally and distally.

Various pathologic diagnoses were made in the cases in which the cysts were totally removed. The most frequent diagnoses were "simple cyst" (11 cases), "developmental cyst" (5 cases), chylous cyst (3 cases), and uncertain cause (4 cases). The remaining cysts were described as being hemorrhagic, lymphangiomatous, inflammatory, or epidermoid.

Two patients in whom retroperitoneal cysts were removed required nephrectomy several months after the original operation, and one of the two patients in whom the cyst was drained had the cyst removed completely several years later. The remaining 29 patients experienced no further difficulty relative to the cyst during the period of follow-up that extended from 7 months to 21 years.

SUMMARY

A review of 32 cases involving retroperitoneal cysts revealed that there were more females (20) than males (12) and most of the patients (28) had nonspecific symptoms referable to the cyst. Pain and an abdominal mass were the most frequent symptoms. An abdominal mass was palpated in 27 patients. Plain roentgenography revealed the mass in 18 of the 29 patients in whom it was done, and an abnormality was demonstrated in 18 of the 24 patients who underwent excretory

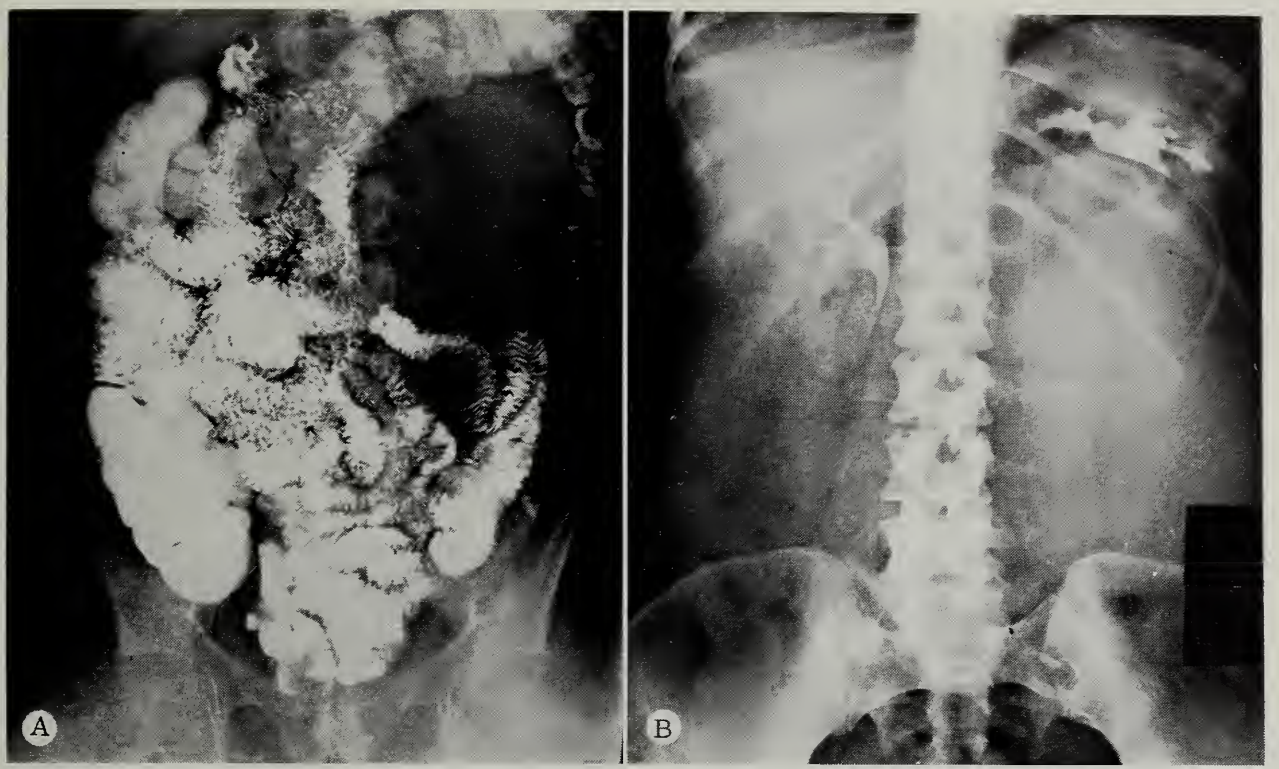


Figure 1. A. Mass in left upper quadrant of abdomen displacing small bowel and colon. B. Retroperitoneal mass displacing left kidney and ureter.

urography. Abdominal exploration was done in all 32 patients, and the mass was removed completely in 29 and subtotally in 1. Two patients underwent incision and drainage only. The cysts were of various pathologic types and were located with equal frequency on the right and left sides of the abdomen. ★★★

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Radiologic Seminar LXXVI: Acquired Diverticulum Of The Rectum

A. J. McILWAIN, M.D.
Jackson, Mississippi

IT IS GENERALLY agreed that diverticula of the rectum are rare. Dr. C. W. Mayo[1] wrote in 1953 that he had never seen a rectal diverticulum and that although acquired diverticula are extremely rare, they may occur. There are reports of a diverticulum of the rectum with abscess formation being diagnosed as a malignancy and the correct diagnosis arrived at only at the time of surgery or after surgery has been performed.[2, 3]

The longitudinal muscle fibers of the rectum afford considerable strength and likely account for the rarity of diverticula in this area. Unlike diverticula of the colon, appendices epiploicae cannot be the causative factor nor play any part in the development of diverticula of the rectum. Increased intraluminal pressure associated with spasm may be a factor in the development of diverticula of the rectum as well as of the colon.

Predisposing causes are thought to be obesity with infiltration of fat into the musculature, sedentary occupation, congenital defects, absence of the coccyx, a relaxed rectovaginal septum, pointed foreign bodies, ulcerated areas, abscess and fistula. Constipation with muscular atrophy and recurring impaction plus increased intraluminal pressure could account for the development of a diverticulum of the rectum.[4] In addition to abscess formation, a diverticulum of the rectum can very well provide a site for the development of a malignancy. ★★★

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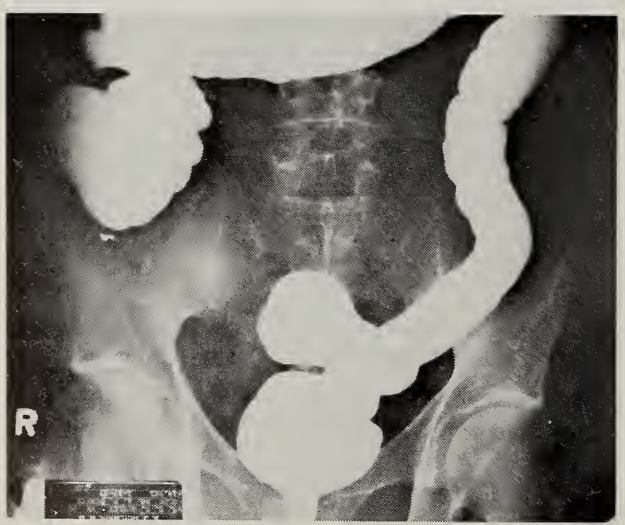


Figure 1. This was made at the time of a colon study on Jan. 16, 1953, and shows no evidence of a diverticulum of the rectum.

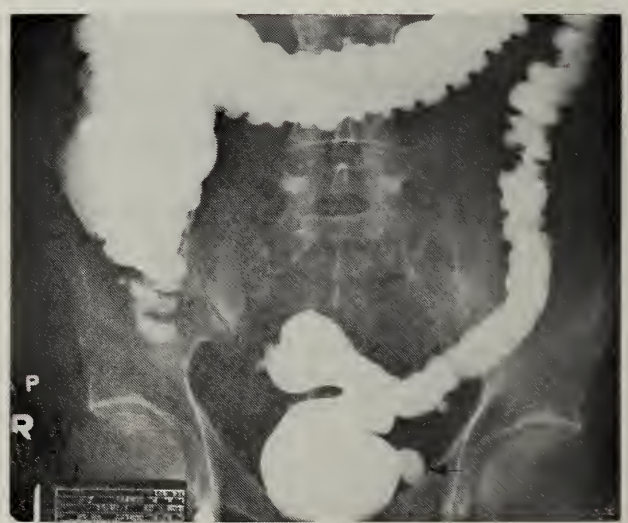


Figure 2. A large diverticulum of the rectum was demonstrated at the time of an examination made 11 years later on March 27, 1964.

Profile of Attainment—Measure of Need, Part II

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

In the second part of the series on the study of postgraduate medical education in Mississippi, the survey of physicians' desires and individual concepts of need on the program is presented. The six part survey sought information as to value of postgraduate programs, assessment of existing educational opportunities, opinion of the proposed institute, instructional preferences, organization of the program, and electronic communications media.

The survey response has been analyzed both by the total reply and by specialty disciplines. In each instance, the conclusions reached are stated.

ONE OF THE MAJOR difficulties, if not impediments, in existing programs of postgraduate medical education is the circumstance of arbitrary uniformity. In selecting a single method of communication or instruction, almost always by the sponsors of the training, many individual desires of the intended beneficiaries, physicians themselves, and their own concepts of personal need in the training must, of practical necessity, be denied. While it is not always possible to tailor a postgraduate education to fit exactly the wishes of each participant and his personal convenience, it is highly realistic to make a serious determination of individual desires and concepts of personal need. Obviously, valid physician opinion should be sought.

The decision was made to survey the membership of the Mississippi State Medical Association. Recognizing that brevity in the questionnaire was essential, areas of inquiry were carefully developed. In the survey pre-test, inquiries were made on the value of postgraduate medical education to physicians, their assessment of existing programs available in Mississippi, their reaction to a permanent postgraduate medical institute as an adjunct to the University Medical Center, their instructional preferences, the organization of a permanent and improved program, and their views on use of electronic communications media, specifically closed circuit television and FM radio.

The survey was conducted according to accepted and valid practices. After development of the questionnaire, originally two pages in length, a pre-test was conducted in Forrest, Leflore, and Coahoma counties. Forrest was selected as small metropolitan; Leflore as medium-small community and rural; and Coahoma as the control.

The pre-test was conducted in January 1968, and from a mailing to 111 members of the association in the three counties, 53 usable returns were received, a response of 47.75 per cent. It was notable that the response from Forrest County was 60.03 per cent which is unusually high.

The questionnaire was further refined in an effort to eliminate all possible bias, and it was reduced to a one-page self-mailer with return postage paid. It was mailed to the membership with a letter of transmittal from the chairman of the council in which he stated that "in endeavoring to assess the true dimensions of the entire area (of postgraduate medical education), we place first priority on the views and opinions of physicians themselves as to what they conceive their needs to be, what sort of program they desire, how they want it organized, and the type of presentations and instructional methods they be-

Chairman, Council on Medical Education and member, Board of Trustees, Mississippi State Medical Association.

Adapted from the study report approved by the House of Delegates, 100th Annual Session, May 13-16, 1968.

lieve to be most effective." The simultaneous mailing was dispatched on Feb. 16, and returns received through March 31 were used.

IBM programs for processing the response were developed in the executive office of the state medical association. Returns were coded only by the study director and associate director to assure uniformity in data reduction. All data processing was done in duplicate to verify effective debugging of the programs, and complete anonymity was assured in that respondents were asked not to identify themselves. Those making subjective comment, as they were invited to do, often signed their names, but such identities were not divulged to members of the council in evaluating the response.

EXCELLENT SURVEY RESPONSE

From among 1,354 questionnaires mailed, a response of 606 was received through March 31. The mailing list was adjusted to exclude certain out-of-state members, i.e., retired physicians, career military medical officers, and residents. Eighteen returns were unusable, leaving a data body of 588 returns, a response of 43.43 per cent. This was deemed excellent and exceeded the hopes of the study task force and the council. Table 1 shows the response pattern by component medical societies.

Nine societies equaled or exceeded the statewide response rate of 43 per cent, and the rate of returns from three major societies, Central, East Mississippi, and South Mississippi which were respectively 48, 51, and 50 per cent contributed immeasurably to the value of the data. Only two societies had a response rate of less than 30 per cent, and 13 of the 17 societies had return rates of more than 35 per cent, the minimum optimal rate for studies of this nature.

The prompt return of most of the questionnaires and the rate of response immediately demonstrated that postgraduate medical education is a subject of concern to Mississippi physicians.

The data were processed from punch cards and displayed in 27 columns at printout. Programs alternately displayed the data (1) for the state at large, (2) by component medical societies, (3) by counties of respondents' residence, and (4) by medical specialties. Further processing in varying combinations made possible more than 100,000 computer comparisons of the 15,000 items of information received in the overall response.

That physicians' records are already automated for IBM data processing at the association's executive offices greatly facilitated the speed with which the survey response was processed and actually made possible the profile of professional attainment, the latter portion of the study requiring a much longer period because of a dozen separate mathematical computations on each physician.

TABLE 1

RESPONSE PATTERN OF SURVEY

Society	*Questionnaires Mailed*	*Usable Rets.*	*Per Cent Usable Rets.*	*Subj. Comt.*	*Per Cent Rets. With Subj. Comt.*
Amite-Wilkinson	11	1	9	0	0
Central Medical	361	174	48	12	7
Claiborne County	3	1	33	0	0
Clarksdale and Six Counties	48	14	29	3	20
Coast Counties	135	53	39	5	9
Delta Medical	126	44	35	4	10
DeSoto County	7	3	43	0	0
East Mississippi	85	43	51	5	12
Homochitto Valley	50	22	44	1	5
North Mississippi	59	22	37	0	0
North Central	37	12	32	1	8
Northeast	115	45	39	2	4
Pearl River	14	8	57	1	12
Prairie Medical	50	22	44	2	10
South Mississippi	148	74	50	11	15
South Central	56	29	52	3	10
West Mississippi	49	21	43	1	5
	1,354	588	43	51	9

TABLE 2

ALL RESPONDENTS

Query	*Total Replies to Query*	*Specific Response*	*Per Cent Opinion Division*
Postgraduate Value	584		
Extremely desirable		286	49
Desirable and helpful		276	47
Not necessary or desirable		22	4
Existing Postgraduate Programs	580		
Inadequate for my needs		196	34
Helpful but need formalizing		307	53
Completely adequate as are		77	13
Proposed Postgraduate Institute	584		
Should have, would participate		277	47
Useful, participate sometimes		272	47
Not necessary at all		35	6
Instructional Preference	580		
Clinically oriented		482	83
Purely didactic		98	17
Postgraduate Organization	558		
On-campus institute, circuits		429	77
Symposia and circuits		112	20
Didactic courses only		17	3
Closed Circuit Television	576		
Important and necessary		229	40
Helpful		303	52
Not needed		44	8
FM Radio Network	526		
Important and TV not needed		22	4
Necessary, complement TV		176	33
FM radio not needed		328	63

Each of the six areas of inquiry will be examined separately, first, by component medical society and the state at large and second, by specialties. Table 2 presents the opinions of all respondents. The first question asked the respondent what a program tailored to his needs and desires meant to him.

PG PROGRAM DESIRABLE

About half of the respondents, 286 out of 584 answering this question or 49 per cent, said that such a program is extremely desirable. Nearly as many, 276 or 47 per cent, said that it is desirable and helpful. Only 22 respondents, a meager 4 per cent, said that it is neither necessary nor desirable. Societies in the northern area, especially those proximal to Memphis, responded in the second and third areas, with fewer stating that it is extremely desirable than the societies in the south whose respondents gave a higher value to a program.

Ninety-six per cent of all respondents believe that a postgraduate program which is structured to their needs and desires is at least desirable and helpful, but half believe it to be extremely desirable. Conclusion:

> *Mississippi physicians believe that a program of postgraduate medical education, tailored to their own needs and desires would be desirable and helpful, and fully half think it extremely desirable.*

Existing postgraduate programs for practicing physicians in Mississippi are largely limited to one-time symposia at the University Medical Center, its circuit course program, and annual sessions of state medical organizations of which the Mississippi State Medical Association's is by far the largest. The second area of inquiry asked the physicians how these available programs measure up in his judgment.

Of 580 answering this inquiry, 34 per cent or 196, said that the available programs are inadequate for their needs and desires. A majority, 53 per cent or 307, said that the existing programs are helpful but a more organized and formalized approach is needed in them. Only 13 per cent or 77 respondents said that the existing programs

were completely adequate as presently constituted. With notably few exceptions, the response was fairly uniform in this respect from all societies. Conclusion:

> *Existing programs of postgraduate medical education available to Mississippi physicians are thought to be helpful by a majority, but a more formalized approach and organization of the programs is believed necessary. A third of the physicians classify existing programs as inadequate, while a very few support the* status quo.

As a logical followup to those who believe that a more organized and formalized approach to continuing medical education is needed, respondents were asked to assume that a Mississippi Postgraduate Medical Institute could be organized, adequately funded, and built as an adjunct to the University Medical Center, made available to all Mississippi physicians for instruction both on-campus and in home communities, for short periods in residence where participants could actually engage in patient care. Then their opinion was solicited as to such a project.

Forty-seven per cent or 277 said that the profession should have the benefit of such a facility and that they would participate. Another 47 per cent replied that the Institute would be useful and that they would participate sometimes. Only 6 per cent of the respondents, 35 physicians, said that the Institute is not necessary at all.

PG INSTITUTE SUPPORTED

The Institute proposal drew heaviest support in the central, eastern, and southern component medical societies and least support from the northernmost societies. In five societies, there were no respondents who felt that it was not necessary at all. Conclusion:

> *A Mississippi Postgraduate Medical Institute, organized and built as an adjunct to the University Medical Center would have support of 19 out of 20 Mississippi physicians who believe that it would be useful and who would participate in its programs.*

It is axiomatic that the manner in which dinner is served is almost as important as the excellence of the food. No subject is more frequently discussed than the structure and format of a medical meeting, and for this reason, respondent physicians were asked to express their preference of instructional methods. A three-part objective response was offered in the pre-test, but it was discovered that virtually all replies were in the two extremes, so the mid-point was eliminated.

CLINICAL INSTRUCTION

Recognizing that almost all medical instruction or essays are didactic, it was decided to seek physician opinion on clinically oriented instruction with concurrent experience in patient management under instructors and wet clinics. An overwhelming majority, 83 per cent or 482 respondents, prefer clinically oriented instruction, while a 17 per cent minority or 98 respondents prefer didactic instructions. With very few exceptions, this reply was uniform in all component medical societies. It is important to note that the question relates to *any* program of postgraduate medical education, which suggests the advisability of planning future state and regional meetings on this format. Conclusion:

> *An overwhelming majority of Mississippi physicians prefer clinically oriented instruction in any program of postgraduate medical education, including concurrent experience in patient management under qualified instructors and wet clinics.*

This inquiry assumed new and greater importance after the returns from the survey were received. The question asked how postgraduate medical education ought best to be organized. The new importance came when a majority of the respondents indicated, in replying to the query on existing programs, that a more organized and formalized approach is needed.

Three out of four respondents, 429 or 77 per cent, said that a combination on-campus institute, clinically oriented, and intensified home area circuit courses which extend the institute approach and the personal services of a faculty adviser on a personal program tailored to needs and desires is the best organization. A fifth of the respondents, 112 out of 558 answering the question, said that the one-time symposia should be continued but that the circuit course program should be intensified. A tiny 3 per cent affirmed their desire for didactic instruction only, making use of circuit courses. Conclusion:

> *Any formal program of continuing education for Mississippi physicians should be organized in a combination of an on-campus postgraduate institute, intensi-*

fied home area circuit courses, and offer participating physicians the personal services of a faculty adviser who would guide in the development of a personalized program tailored to meet the individual's needs and desires.

The final area of inquiry was about the physician's concept of the usefulness of electronic communications media in postgraduate medical education. The growing importance and utilization of these media, closed circuit television and FM radio, suggested that at some future time use might be made of them in Mississippi.

About four out of 10 respondents believe that closed circuit television with receivers in each hospital are important and necessary in a postgraduate program. A majority, 303 out of 576 answering the question or 52 per cent, believe that TV would be helpful. Eight per cent thought it not needed.

The inquiry on FM radio brought the most shocking surprise in the study. Being much less expensive than television and a "passive" medium which does not require the undivided attention of the listener, FM radio has been the subject of many articles and papers as a useful communications device in postgraduate medical education.

A substantial 63 per cent of the respondents, 328 out of 526 answering this question, said that FM radio is not needed. A third, 176 respondents, felt it necessary and that it could complement medical television. Only 4 per cent classified FM radio in postgraduate medical education as important and necessary and that television would not be needed. Conclusion:

At some future time when a program of postgraduate medical education has been developed in Mississippi on a formal and organized basis, a closed circuit television system with receivers in hospitals and other facilities convenient to physicians would be a valuable adjunct to the program. An educational radio network is not an acceptable communications medium for this program.

LOYALTY TO SPECIALTIES

All doctors of medicine are physicians first, but their respective professional lives are almost totally adjusted to their spheres of professional interest. It is almost axiomatic that a physician's first loyalty is to his specialty society, and this is as logical as it is correct. He shares with his similarly devoted colleagues a common interest which is difficult to describe, and his views are more often than not coincidental with theirs. If this study proved nothing else, it clearly demonstrates this point.

In conceiving and structuring any formal program of continuing medical education for Mississippi physicians, it was deemed essential to discover and identify the wishes of the several specialties, including general practice, and to report these views with accuracy and faithful representation.

SUBJECTIVE QUERIES

One of the first subjective inquiries in the questionnaire was "my specialty or chief interest . . ." and responses were coded accordingly by the study director and associate director. Certain interpretations had to be made, because the fact that the responses were subjective made this necessary. For example, a number of respondents classified this area as "general practice and surgery." It has been previously recognized that general practitioners do perform competent surgery, but for purposes of this study, each was classified in a nonsurgical discipline.

Comparable replies were dealt with accordingly, always in the most conservative possible interpretation. Again, this was a deliberate effort to avoid distortion of the data, and in so doing, there was no conscious desire to do injustice to any respondent. Both the council and the study task force felt it imperative to underplay the response rather than to try to read interpretations into it. Over all else, we value the integrity of the study, and nothing was spared to assure this achievement.

Seven of the nonsurgical disciplines, pediatrics, radiology, internal medicine, general practice, preventive medicine, dermatology, and allergy responded with more than 50 per cent in stating that a formal program of postgraduate medical education is extremely desirable to me as a physician. These same seven disciplines also state that a formal postgraduate medical education program tailored to their needs and desires is extremely desirable by a response of 50 per cent or more.

Dermatologists stood alone at 72 per cent, while the remaining groups replied by rates of 50 to 60 per cent. The remainder took a moderate view that such programs would be desirable and useful, and only a very small minority felt that such a program is not necessary or desirable. The latter group corresponded almost identically to the overall response.

None of the surgical specialties indicated a value assessment of more than 50 per cent, most

taking the view that such a program is desirable and helpful. It is significant to note that EENT and orthopaedic surgery had responses of only one out of four stating that such was extremely desirable. But it is also significant to note that high value is placed on such programs by those in obstetrics and gynecology, ophthalmology, and general surgery. Conclusion:

> *Mississippi physicians in nonsurgical specialties appear to place a higher value on postgraduate medical education programs than those in the surgical specialties, but the degree of difference is not in an extreme. The "overlapping specialties," i.e., general practice, internal medicine, and pediatrics, are far more eager to establish formal programs than are the "nonoverlapping" specialties. There is, however, no significant lack of interest in formal programs among all practitioners in the state.*

There is almost total agreement among all responding disciplines on one aspect of existing postgraduate medical education programs available to them in Mississippi: These are not fully adequate as presently constituted. A more notable division of opinion emerges as to the degree of inadequacy, and this is the vital element in this segment of the response.

Strong majority opinion as to program inadequacy was expressed by 57 per cent of the psychiatrists and neurologists, 58 per cent of the pathologists, 76 per cent of the ophthalmologists, 86 per cent of the dermatologists, and an overwhelming 88 per cent of the anesthesiologists. At the other extreme of the spectrum, just 29 per cent of the pediatricians, 25 per cent of the internists, and 24 per cent of the general practitioners found existing programs inadequate.

BETTER ORGANIZATION

Among the nonsurgical disciplines, there was consistent agreement by about half of the respondents that present postgraduate programs were helpful but needed a more formalized and organized approach. This is apparent with 57 per cent of the pediatricians, 59 per cent of the internists, and 62 per cent of the general practitioners. It is significant how these "overlapping" fields tend to agree on many of the survey queries.

General Surgeons call existing programs inadequate by 46 per cent, but 48 per cent of them say the programs are helpful with more formalization and organization indicated. With the exceptions of ophthalmology, otolaryngology, and EENT, again close together, the surgical specialties hovered around the norm established in the overall response to the query. Conclusion:

> *There is almost total agreement among surgical and nonsurgical specialties in Mississippi that existing postgraduate medical education programs are not completely adequate as constituted. The degree of inadequacy varies among the nonsurgical fields. Most believe present programs helpful but urge a more organized and formalized approach.*

MEDICAL SPECIALTIES SPEAK

The three numerically largest nonsurgical specialties speak with strong voices in support of the proposed Mississippi Postgraduate Medical Institute. Half of the pediatricians, 49 per cent of the internists, and 52 per cent of the general practitioners say that the profession should have the benefit of the facility and its services. The psychiatrists and neurologists similarly respond with 47 per cent, and the pathologists with 43 per cent.

The surgical specialties have strong spokesmen, too, with the ophthalmologists urging at the rate of 59 per cent, the general surgeons, again close to the overall norm, at 46 per cent, the otolaryngologists at 50 per cent, and urologists at 62 per cent. The dermatologists led the balloting of endorsement with 86 per cent.

Not a single opinion that the institute was unnecessary came from nine disciplines: Ophthalmology, otolaryngology, dermatology, urology, preventive medicine, thoracic surgery, pulmonary diseases, allergy, and the miscellaneous or unclassified group.

Four specialties showed least enthusiasm for the institute. These are EENT at 15 per cent, orthopaedic surgery at 33 per cent, obstetrics and gynecology at 28 per cent, and anesthesiology at 25 per cent. The orthopaedic surgeons oppose the institute by a rate of 42 per cent.

Most disciplines also said by slightly less than half that the institute would be useful and that they would participate sometimes. Conclusion:

> *The numerically larger surgical and nonsurgical specialties support the postgraduate institute proposal by substantial majorities. In all but four specialties, at least nine out of 10 expressed support and indicated in varying degrees*

that they would participate in its programs.

The degree of variation in the overwhelming preference for clinically oriented instruction within each of the surgical and nonsurgical specialties is statistically insignificant. The 5-to-1 preference for clinically oriented instruction as opposed to purely didactic instruction found in the overall response where 580 replied to the question is clearly typical among the specialties with notably few exceptions.

Radiologists are about 6-to-4 for clinically oriented instruction, but the numerically largest group of respondents, the general practitioners are 89 per cent, 9-to-1, for it, and the psychiatrists and neurologists gave an astonishing 20-to-1 endorsement. The general surgeons were precisely at the overall response norm. Conclusion:

Each specialty gives an overwhelming endorsement to clinically oriented instruction in any program of postgraduate medical education.

PATHOLOGISTS DIFFER

Only a single specialty, pathology, failed to express a majority opinion that any formal postgraduate medical education program should be organized as a combination of an on-campus institute, clinically oriented, with home area circuit courses and personal services of a faculty adviser on personal programs tailored to individual needs and desires. Conclusion:

Specialists, as individual groups, are consistent in believing that any postgraduate medical education program should be organized as a combination of an on-campus institute, clinically oriented, with home area circuit courses, and the personal services of a faculty adviser in personally designed programs.

TV DEEMED USEFUL

The specialties, as individually considered groups, are consistent with the overall response to the importance of closed circuit television as an adjunct to postgraduate medical education. With rare exception, about four out of 10 believe it important and necessary, with slightly more than half saying that it would be useful. Only a very few feel TV to be unnecessary.

The overall response to the usefulness of FM radio in postgraduate programs is faithfully repeated by the specialties, sometimes with greater emphasis than was noted in the 25-to-1 opinion for all respondents. Voting zero for FM radio were EENT, orthopaedic surgery, radiology, psychiatry and neurology, and pathology.

Among the largest nonsurgical groups, only 8 per cent of the pediatricians, 4 per cent of the internists, and 6 per cent of the general practitioners favored FM radio. Only 1 per cent of the general surgeons, a single respondent, favored it. Conclusion:

Most specialists find merit in some degree in use of closed circuit television with receivers in hospitals and other convenient locations, but they believe in overwhelming numbers that FM radio is not desirable or necessary. ★★★

2500 N. State St. (39216)

This study was assisted in part by the Regional Medical Program of the University Medical Center, Jackson.

MONAURAL MATERNITY

"I simply cannot agree with your theories of prenatal influence," said the senior medical student to the psychiatry instructor. "Take my own personal case, for example. My mother was accidentally hit with a broken phonograph record just before I was born, but it didn't affect me, affect me, affect me . . ."

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Dec. 1-4, 1968, Miami Beach, Fla.; Annual Convention, July 13-17, 1969, New York, N.Y. F. J. L. Blasingame, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

American Academy of General Practice, Annual Meeting, Sept. 13-20, 1968, Las Vegas, Nev. Mr. Mac F. Cahal, Executive Director, Volker Blvd. at Brookside, Kansas City, Mo. 64112.

Southern Medical Association, Annual Meeting, Nov. 18-21, 1968, New Orleans, La. Mr. Robert F. Butts, Executive Director, 2601 Highland Ave., Birmingham, Ala. 35205.

STATE AND LOCAL

Mississippi State Medical Association, 101st Annual Session, May 12-15, 1969, Biloxi. Mr. Rowland B. Kennedy, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Mississippi Academy of General Practice, Annual Assembly, Oct. 15-17, 1968, Biloxi. Miss Louise Lacey, Executive Secretary, P. O. Box 1435, Jackson 39201.

Amite-Wilkinson Counties Medical Society, Third Monday March, June, September, December. S. E. Field, Jr., Centreville, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. William O. Barnett, Suite B-6, Medical Arts Building, Jackson, Secretary.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Port Gibson, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday April and First Wednesday November, 2:00 p.m., Clarksdale. Walter T. Taylor, P.O. Box 668, Clarksdale, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, July and November. C. Hal Cleveland, P.O. Box 1018, Gulfport, Secretary.

Delta Medical Society, Second Wednesday April and October. Howard A. Nelson, 308 Fulton St., Greenwood, Secretary.

DeSoto County Medical Society, Second Thursday, January, April, July, and October, 1:00 p.m., Mary's Restaurant, Hernando. Malcolm D. Baxter, Jr., McIntosh-Baxter Clinic, Hernando, Secretary.

East Mississippi Medical Society, First Tuesday February, April, June, August, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian, Secretary.

Homochitto Valley Medical Society, First Tuesday Quarterly, Jefferson Davis Memorial Hospital, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez, Secretary.

North Central District Medical Society, Second Wednesday March, June, September, and December. Herbert R. Power, Vaiden Clinic, Vaiden, P.O. Box 85.

Northeast Mississippi Medical Society, Second Tuesday, March, June, September, and December. S. Jay McDuffie, Nettleton, Secretary.

North Mississippi Medical Society, First Thursday, April and October, Cherie Friedman, 1004 Jackson Ave., Oxford, Secretary.

Pearl River County Medical Society, Second Monday every month. J. M. Howell, 215 Kirkwood St., Picayune, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, December. L. H. Brandon, Jr., 305 University Dr., Starkville, Secretary.

South Central Mississippi Medical Society, Second Tuesday March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb, Secretary.

South Mississippi Medical Society, Second Thursday March, June, September, and December. John E. Green, P.O. Box 1230, Hattiesburg, Secretary.

West Mississippi Medical Society, Second Tuesday January, April, July, and October, 7:00 p.m., Old Southern Tea Room, Vicksburg. Martin E. Hinman, 1513 Clay Street, Vicksburg, Secretary.

Proceedings of the House of Delegates

100th Annual Session
May 13-16, 1968
Jackson, Mississippi

THE 65TH ANNUAL SESSION of the House of Delegates was convened during the 100th Annual Session of the Mississippi State Medical Association, in pursuance to lawful notice given, on May 13, 1968, in the Rose Room of the Hotel Heidelberg at Jackson, Mississippi, at 9:08 o'clock in the morning, by Dr. Temple Ainsworth, the President. The invocation was spoken by the Rev. Dr. W. Douglas Hudgins, Pastor of the First Baptist Church, Jackson, Mississippi.

After extending greetings, Dr. Ainsworth presented the Vice Speaker, Dr. James L. Royals of Jackson, and the Speaker, Dr. William E. Lotterhos of Jackson, who assumed the chair. Dr. Walter H. Simmons, Chairman of the Reference Committee on Credentials, reported the presence of a quorum of registered and seated delegates in accordance with Section 3, Chapter V, By-Laws of the association.

ANNOUNCEMENT OF REFERENCE COMMITTEES

Reports of Officers and Board of Trustees
- C. G. Sutherland, Jackson, Chairman
- Archie C. Hewes, Gulfport
- C. R. Jenkins, Laurel
- Leo J. Scanlon, Jr., Natchez
- Rhea L. Wyatt, Holly Springs

Medical Practices
- Howard A. Nelson, Greenwood, Chairman
- J. M. Griffith, Columbus
- Joseph B. Miller, Jackson
- Charles B. Mitchell, Jr., Meridian
- W. B. Winstead, Pascagoula

Miscellaneous Business
- Jack A. Atkinson, Brookhaven, Chairman
- Arthur A. Derrick, Jr., Durant
- John G. Egger, Drew
- Robert P. Henderson, Jackson
- Stanley A. Hill, Corinth

Credentials
- Walter H. Simmons, Jackson, Chairman
- T. K. Chandler, Tunica
- Prentiss F. Keyes, DeKalb

Rules and Order of Business
- Frank M. Davis, Corinth, Chairman
- Angus M. McBryde, Sumrall
- Loutrelle Stribling, Carthage

APPOINTMENT OF TELLERS AND SERGEANTS-AT-ARMS

W. M. Dabney, Crystal Springs, Chairman
Arthur A. Derrick, Jr., Durant
J. Daniel Mitchell, Jackson

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

To assist the Speaker and Vice Speaker in the orderly conduct of the proceedings of this House of Delegates, your Reference Committee on Rules and Order of Business makes the following recommendations:

Conduct of Business. Under the By-Laws, the business of the House must be conducted according to *Robert's Rules of Order, Revised,* and the Speaker and Vice Speaker should prescribe the order of business as set out in the By-Laws. To insure proper recording of the transactions, all delegates recognized should identify themselves. Except for distinguished visitors and those having official capacity in the association, unanimous consent should be obtained for extending the privilege of the floor to nonmembers of the House of Delegates. The report of the Reference Committee on Credentials should constitute the formal and official roll call of the House.

Reference Committees. The purpose of reference committees is for affording all members of the association an opportunity to discuss their views on matters under consideration by the House of Delegates.

Reports. All reports and resolutions presented should be referred to the appropriate reference committee by the chair immediately after their presentation, the only exception being those which are of such a nature as to require no further consideration and are, therefore, ready for decision by vote of this House. Reports published in the *Handbook of the House of Delegates* are considered to have been formally presented and should be referred to appropriate reference committees by the chair. Debate should be reserved on all such presentations until such time as the reference committees conduct formal hearings and when they report to the House.

Resolutions. To avoid burdensome tasks upon the reference committees and to insure that all members have adequate opportunity to discuss their views, the House should permit no introduction of resolutions after the present meeting except for (1) matters of an emergency nature, the validity of such emergency to be determined by majority vote, (2) matters relating to a scientific section or scientific work, and (3) proposed amendments to the Constitution and/or By-Laws which would then lie on the table for one year.

The report of the reference committee was adopted.

ADOPTION OF TRANSACTIONS

On motion by Dr. C. D. Taylor, Jr., of Pass Christian, second by Dr. John B. Howell, Jr., of Canton, the Transactions of the 64th Annual Session of the House of Delegates, 99th Annual Session of the association, May 15-18, 1967, Biloxi, published in Volume VIII, Number 8, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, August 1967, were adopted.

REMARKS OF THE SPEAKER

Dr. William E. Lotterhos: Your Speaker and Vice Speaker extend warm greetings to our colleagues on the occasion of the 100th Annual Session of our association and the 65th Annual Session of our House of Delegates. While the annual session of our association is the largest annual postgraduate medical education event in Mississippi, it is also the time for reviewing the work of the few who serve the many. It is the time for us to accept the challenge of crucial issues. It is the time for us to set the course for the year to come.

Your speakers are referees, umpires, and servants to this House of Delegates. Our only tasks involve your doing your own deciding according to the rules. We will try to give you a good playing field, prompt and fair calls, and, hopefully, a fast game.

Before the first whistle blows, let's meet at the side of the field for a moment and agree on a few matters. Business brought before us will be presented by the appropriate official body of the association, usually by the chairman, or by an individual officer. All business, except for that which obviously requires no further consideration or action, will be referred by your speakers to the appropriate reference committee.

When matters are thus presented today, there may be no debate, because the opportunity for all to debate has been scheduled. Those having an interest in a matter officially before us should be present at the reference committee hearing where he may present his views and make his recommendations.

When the reference committees have heard all who wish to be heard, they will enter into executive session to prepare their respective reports. We will receive these on the final day of the annual session where, again, we have the opportunity for debate on the floor of the House.

But a word of caution: Each of us here has something to contribute to our decision on each issue before us. Such views do us no good when the delegate is absent from the reference committee hearing. It is also something of an affront to the House for a delegate who was absent from the reference committee to arise for repetitious debate which has been fully conducted in the reference committee hearing. We are sure that this respectful injunction applies to so few among us as to make its expression almost needless.

Your speakers have tried to plan for your convenience in the conduct of our proceedings. Those reports which were ready in late February have been published in your April JOURNAL, so that every member of the association may know in advance of them. Through no small effort, the remaining reports and such resolutions as we were able to obtain in advance of the meeting are in your folders.

It has not been too many years ago when we sat emptyhanded in this House and heard reports read from the only existing manuscript. Let us make fruitful use of the services which have been performed for us.

Few among us are expert parliamentarians, but we are fair and sincere, eager to make good decisions for the good of medicine and our patients. Let us, therefore, keep our parliamentary procedures simple and direct. Let us avoid the tangle of motions and tactics which confuse rather than clarify and which offer heat rather than light. Some worthy issues have been lost through the

maze and snarl of such vexing engagements when the majority, in hopelessness or disgust, summarily disposes of the matter just to rid itself of the mess.

When the chair has reason to believe that debate or discussion is neither relevant nor germane, the appropriate ruling will be promptly made. When the intent of a motion is inquired, the chair will also rule. But your speakers make no claim as to infallibility, and your right of challenge will be recognized with equal promptness.

Often, in debate, a proponent or opponent makes a substitute motion which is the exact opposite of the main motion. Whether he is in the majority or minority, he has needlessly wasted the time of his colleagues, because the same "yeas" and "nays" will prevail. Be respectfully advised in this connection.

Your Speaker, as a general officer of the association, has reason to be forcefully aware of the work which is carried on by our official bodies. In the Board of Trustees alone, agenda, exhibits, studies, reports, and minutes during the 1967-68 association year numbered in the hundreds and hundreds of pages. It is perfectly true that a 10 minute report to this House can and sometimes does represent half a dozen meetings, as many days given from practice, and thousands of man miles of uncompensated travel.

Let us consider seriously, weigh heavily, speak wisely, and decide prudently on each matter before us. It represents work and sacrifice in our behalf. In addition, we have a responsibility to those physicians in our respective societies whom we represent to do our best in our wisest way.

Your Speaker invites the attention of the House to Section 7, Chapter V, By-Laws of the association, which provides for our reference committees. The section prescribes the appointment of these committees by the President.

Now, this House of Delegates is the legislative arm of our association. The President of the United States does not appoint the committees of the Senate and the House of Representatives. The same is true in the constitutional governments of the several states.

The presidents of the American Medical Association and the American Academy of General Practice do not appoint reference committees in the AMA House or the AAGP Congress of Delegates.

The reason for this is simple: These are committees of the legislative body which exist and work only during sessions of the legislative body. It seems only correct that the officer charged with the conduct of the body should carry the responsibility of making these appointments. Yet, our By-Laws repose this responsibility in the president.

Your Speaker recommends that so much of Section 7, Chapter V, By-Laws of the association as reads "Sufficient reference committees shall be appointed by the President . . ." be amended to read "Sufficient reference committees shall be appointed by the Speaker. . . ."

Let us now be about the business of our association with firm resolve, enlightened action, and sound judgment.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your Reference Committee considered the remarks of the Speaker of the House of Delegates except for that portion recommending an amendment to the By-Laws. We express our appreciation to the Speaker for his constructive remarks and exercise of leadership, and we commend both Drs. Lotterhos and Royals for their fair and impartial conduct of the deliberations of this House of Delegates.

We also express our appreciation to our fine presiding officers for the innovations which they have effected for the convenience and expedition of the business of this House of Delegates.

Your Reference Committee in approving the remarks of the Speaker asks the House to associate itself in this expression of commendation.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

The Speaker of the House of Delegates in his splendid address to us at the opening meeting of the House recommended that Section 7, Chapter V, By-Laws of the association be amended to read that "sufficient reference committees be appointed by the Speaker." The By-Laws now require that the President of the association appoint reference committees.

The appointive power in our association is reposed in our President. Under the By-Laws, he is charged with replacing any officer or Trustee who resigns, dies in office, or is otherwise terminated prior to the expiration of his term of service.

Your council believes that this is a healthy and wholesome balance of power between the legislative and executive arms of our state medical association, and we, therefore, recommend that the proposal of the Speaker of the House of Delegates be not adopted.

The report of the council, acting as a reference committee, was adopted.

PRESENTATION OF DISTINGUISHED GUESTS

The Speaker presented the following distinguished guests and members of the association:

Dr. David B. Wilson, Jackson, President of the American Hospital Association.

H. H. McClanahan, Jr., Columbus, Trustee Emeritus.

Mr. Whalen M. Strobhar, Chicago, Illinois, Field Representative, American Medical Association.

Mr. Edward Uzemack, Chicago, Director, Department of Service to Officers, American Medical Association.

Mr. John P. Lee, Carthage, and Mr. Jimmy Lawson Smith, Meridian, Student Delegates, University of Mississippi School of Medicine.

And the following representatives of the Mississippi Hospital and Medical Service, Inc., Jackson:

Mr. William J. Shakelford, Vice President.

Mr. Charles Caffey, Professional Relations Representative.

Mr. Warren Edwards, Professional Relations Representative.

Mr. Gerald Franciskato, Professional Relations Representative.

ADDRESS OF THE PRESIDENT

The Speaker declared the House of Delegates in open session, and the President, Dr. Temple Ainsworth, delivered his address. The address has been published separately in Volume IX, Number 7, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, July 1968.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your Reference Committee heartily and enthusiastically commends the President of our association, Dr. Temple Ainsworth of Jackson, for his outstanding service to Mississippi medicine during the year just passed and his splendid address which was delivered to this House of Delegates.

Your Reference Committee believes that Dr. Ainsworth will long be remembered in the history of medicine in Mississippi for his substantial contributions to the work of our association and for his exercise of medical statesmanship and leadership during his year of service. (Applause)

Your Reference Committee endorses and supports the proposal of the President for each component medical society of the association to establish a fee review committee where able, knowledgeable members are appointed to serve and we concur with his proposal to make the services of these committees available to patients, physicians, hospitals, pre-payment and voluntary health insurance organizations, employers and voluntary and governmental agencies. Your Reference Committee requests that the Board of Trustees assist in this endeavor by offering such services as may be made available to component medical societies in organizing and establishing fee review committees.

Your Reference Committee wishes to quote a portion of Dr. Ainsworth's address which has been so favorably received by this House of Delegates:

> "Let us be for a workable, realistic and just means of purveying medical care to all as we have always been but not necessarily as we have always done. Let us sit with knowledge and purpose in the councils of government, industry and every appropriate segment of society, and let us speak frankly and sincerely but with reason and calm.
>
> "If our science is firmly positioned in the seventh decade of the 20th Century, our philosophy ought also to be there with it. . . ."

Your Reference Committee asks that this House of Delegates associate itself in approving Dr. Ainsworth's address and that we extend sincere commendation to him for his great service to us.

The report of the reference committee was unanimously adopted as the House of Delegates accorded the President a standing ovation.

SPECIAL ADDRESS

Dr. Dwight L. Wilbur of San Francisco, President-elect of the American Medical Association, addressed the House of Delegates as the principal guest speaker of the 100th Annual Session.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

99th Annual Session. At the 1967 annual session, there were no pending amendments to the Constitution or By-Laws, and none was acted upon during the meeting. One amendment to the By-Laws was introduced on the final day of the 99th Annual Session to lie on the table for one year for consideration at the 100th Annual Session.

Resolution No. 7. At the adjourned meeting of the House of Delegates on May 18, 1967, Drs. S. Lamar Bailey and H. C. Ricks introduced Resolution No. 7, subject: Limitation Upon Terms of AMA Delegates. The resolving clause is as follows:

> *Resolved,* That so much of Section 6, Chapter V, By-Laws of the Mississippi State

Medical Association as reads: "It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two successive years," be amended to add the following: "provided, however, that no individual so elected shall serve more than three successive terms."

The proposed amendment is now pending before the House of Delegates, and your council will conduct hearings at the time appointed during the 100th Annual Session, so that the views of all concerned may be expressed and considered for making recommendations for final action on the proposal. Your council notes that no incumbent Delegate to AMA would be affected by the amendment at the present annual session and that no departure from customary procedures in matters of this nature is necessary. Your council will also be prepared to consider any and all other proposed amendments which may be brought before the present annual session.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your Council on Constitution and By-Laws considered the Resolution No. 7, introduced at the 99th Annual Session in 1967 by Drs. H. C. Ricks and S. Lamar Bailey, Past Presidents. This resolution proposes a limitation upon the current consecutive terms of service which an AMA delegate could serve. Your council points out that the House of Delegates is able to exercise a choice in the selection of AMA delegates through the ballot. We also recognize that seniority is of great importance in the AMA House of Delegates. Accordingly, your council recommends that Resolution No. 7 from the 99th Annual Session be not adopted. Your council also takes note of the fact that Dr. H. C. Ricks has withdrawn his sponsorship of this resolution.

The report of the council, acting as a reference committee, was adopted.

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties. The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties, the Board shall have conducted eight meetings since the 99th Annual Session when this report is considered by the House of Delegates. The Board met in May, June, July, August, and December of 1967 and in February of 1968. Meetings are scheduled for April and May of 1968. This annual report includes actions on matters referred by the House of Delegates and those items relating to management and policy functions among the Board's responsibilities.

Referrals from the House of Delegates. Matters referred by the House of Delegates at the 99th Annual Session and actions by the House requiring consideration by the Board include:

(a) *Emergency Medical Care Unit.* The House of Delegates voted to continue the Emergency Medical Care Unit during regular and special sessions of the Legislature and asked that the Board restore the necessary funds to the annual budget for operation of the unit. The Board acted immediately to appropriate $3,000 for this purpose, and the unit was opened with the convening of the 1968 regular session. In keeping with the action of the House which recognized staffing difficulties in securing Doctors of the Day, the Board has called on all members to volunteer their services for one day in this activity. A registered professional nurse has been employed and is present in the unit during each legislative day.

(b) *Joint Billing of AMPAC and MPAC Dues.* At the request of the Mississippi Medical Political Action Committee, the House approved joint billing of PAC dues with annual membership dues by component medical societies of the association. This approval is conditional upon the billing statement clearly showing that PAC dues are voluntary and not deductible for tax purposes. This was formally communicated to each component medical society and was published in the JOURNAL. The Board is gratified with the response of the membership in this connection.

(c) *Resolution No. 3.* The House of Delegates adopted Resolution No. 3, subject: AMA Aims, introduced by the Delta Medical Society, at the 99th Annual Session. The AMA delegates introduced the resolution at the June 1967 annual convention of AMA at Atlantic City, and it was referred to the Board of Trustees. At the Houston clinical convention in 1967, the AMA Board recommended an 11-point statement of aims and purposes which greatly enlarged upon the previous declaration of purposes. In brief, the newer statement dedicates the skills and resources of the world's largest medical organization to a continuing effort to stimulate progress in all aspects of health care in America. The Board takes this opportunity to emphasize that the action of a single Mississippi component medical society has influenced the formulation and adoption of a major policy statement of the AMA.

(d) *MSMA Building.* The House of Delegates approved a proposed expansion of the association's Central Office Headquarters Building and gave the Board of Trustees necessary authority to construct the addition after consideration of bids and the awarding of contracts as has been done with the building in the past. A number of considerations prompted the Board to defer the construction project during the year, among which was the death of the architect. The need for increased space still exists, and the Board requests the House of Delegates to reconfirm the authority given in 1967 under the same stipulations and circumstances.

Association Insurance Programs. The Board of Trustees continues to monitor the various group insurance programs which have been made available to the membership. The Continental Casualty Co. of Chicago, through our state administrator, Thomas Yates and Co. of Jackson, offers seven categories of coverage including income replacement, life and 65, senior over-70 income supplement, catastrophic hospital plan, inhospital indemnity plan, senior Medicare supplement, and overhead expense plan. As many as 475 members per plan have purchased this coverage, and there are variations available under each category. The plans are stable, actuarially sound, and generally reflect a favorable experience. While the association is in no way engaged in the operation or administration of these plans, each is carefully monitored by the Board, and no contract revisions are made without the Board's approval.

Professional Liability Insurance. The St. Paul program which has been available to the membership since 1961 has directly influenced a premium reduction in Mississippi for this insurance of about 50 per cent. Despite the profound national trend of increasing premium rates for this essential coverage, the Mississippi program continues as one of the least expensive with a national ranking of 48th in cost. The membership is reminded, however, to purchase sufficient professional liability coverage and in the event of threatened or actually instituted litigation, to make use of review and advisory services which are available to all from the Board of Trustees. As with the Continental programs, the Board continually monitors the St. Paul program in detail as to written and earned premiums, rating structures, incurred losses, and loss ratio experience. At this reporting, 477 members have availed themselves of this coverage.

CHAMPUS Program. During 1967, the Civilian Health and Medical Program of the Uniformed Services, formerly known as the Dependents' Medical Care Program or the original Medicare, was substantially expanded with the implementation of Public Law 89-614 which included retirees and certain survivors. Additionally, outpatient services were authorized, subject to an annual deductible amount and a co-pay provision. Claims volume increased more than 400 per cent from the fall of 1967 through January of 1968, and it was necessary to double the staff in this department. Effective March 1, 1968, the association was successful in arranging a conversion from the former schedule of maximum allowances to payment of physicians' fees on a usual, customary, and prevailing basis. This concept, in effect, covers the 90 percentile in virtually every instance.

Regional Medical Program. The Mississippi Regional Medical Program has been established by the National Institutes of Health at the University Medical Center at Jackson. Dr. Guy D. Campbell of Jackson is the coordinator, and the region in which the program is operated has been defined to coincide with state boundaries. While the law under which these programs are developed specifically mentions heart disease, cancer, and stroke, the basic goal is to reduce any gaps between the potentialities of medical science and the realities of existing services and facilities.

Initial emphasis in the Mississippi program has been placed upon post-graduate medical education, a concept which the association supports. In this connection, our Council on Medical Education has conducted a comprehensive study, and the findings and recommendations are separately reported by the Board of Trustees.

During 1967, Dr. L. T. Carl of Jackson, who has represented the association as a member of the regional advisory group to the program resigned, and Dr. James L. Royals has been appointed to succeed him. The Board of Trustees regularly receives reports on the Mississippi program.

Blue Cross-Blue Shield Directors. On August 8, 1967, Dr. M. Q. Ewing, one of the 12 physician-directors of the Mississippi Hospital and Medical Service, Inc., died. The Board of Trustees nominated Dr. Stanley A. Hill of Corinth to succeed Dr. Ewing and to serve the unexpired portion of his term to 1969.

The Board has considered the custom observed in the selection of nominees for the Blue Cross-Blue Shield board of directors who are not contested on the ballot as is the case with all other officers for which the House of Delegates votes. The selection of nominees for these appointments is not prescribed in the By-Laws of the association. Believing that delegates should be able to express a choice, the Board believes that eight members

should be proposed on the ballot by the Nominating Committee and that the four receiving the greatest number of votes be declared the nominees of the association for the posts due for appointment. The Board will separately make a proposal with reference to formalizing this procedure in the By-Laws.

Board of Trustees of Mental Institutions. Under the provisions of Section 6946-02, Chapter 3, Mississippi Code of 1942, Annotated, the association is obligated to submit nominations to the Governor of Mississippi from which he appoints physician-members of the Board of Trustees of Mental Institutions. The Board consists of two physicians and three members from the public at large, and terms are for six years each.

The association was informed that the term of Dr. James Grant Thompson of Jackson would expire on March 17, 1968, so the Board of Trustees of the state medical association, acting under the law, made the required five nominations to Governor John Bell Williams. The nominees were:

William B. Howard, Pontotoc
John E. Lindley, Meridian
Fred M. Sandifer, Jr., Greenwood
James Grant Thompson, Jackson
George M. Wilson, Gulfport

State Board of Health. At the 99th Annual Session in 1967, the House of Delegates made nominations for the State Board of Health for Public Health Districts 1 and 3, as prescribed by Section 7024, Mississippi Code of 1942, Annotated. The nominations were submitted to then-Governor Paul B. Johnson on May 29, 1967, and terms of the posts for which the nominations were made expired on December 31, 1967. Governor Johnson did not act on the recommendations, and these were resubmitted to Governor Williams soon after his inauguration.

Fluoridation of Water Supplies. At the 93rd Annual Session in 1961, the House of Delegates approved fluoridation of water supplies in amounts not to exceed one part per million. The Mississippi Dental Association has recommended that "the Mississippi State Board of Health consider promulgating a statewide regulation concerning minimum standards for approval of public water supplies which include that the fluoride content be adjusted to the recommended level of one part per million," and the Board concurs in the proposal and has approved it.

Medicine and Religion. The Committee on Medicine and Religion has represented the association on two occasions at national meetings during the year, and the committee has acted in behalf of the association in cosponsoring the Seminar on Medicine and Religion at the University Medical Center March 14-15, 1968. The Board commends the committee for its work in this program and in conceiving the idea of the seminar. The Board notes with pride that His Excellency, the Most Reverend Joseph B. Brunini of Jackson, Bishop of the Diocese of Mississippi, has been appointed a member of the AMA Committee on Medicine and Religion.

Journal MSMA. Our JOURNAL, now in its ninth year, enjoyed its second best year in advertising revenues during 1967. Of greater importance has been the increase in the quality of scientific papers and Mississippi medical news regularly published in the JOURNAL. The recently adopted regulations of the U. S. Internal Revenue Service which tax so-called unrelated income from scientific publications of exempt organizations have been carefully reviewed by the Board. We have asked our certified public accountants to work closely with the executive staff in assigning all lawful charges against such revenues. The Board warmly commends the Committee on Publications and the Editors for their services to the scientific work of the association and for their continued successes in this, the largest single association-owned and sponsored project.

Organization of the Board. Three new members of the Board were welcomed during the association year. Drs. John M. Alford, Jr., of Greenwood and James O. Gilmore of Oxford were seated as regularly elected Trustees for Districts 1 and 2, respectively. Dr. G. Swink Hicks of Natchez, the District 8 Trustee, resigned effective December 7, 1967, to assume his new duties as Delegate to the American Medical Association. He further serves as a member of the State Board of Health and as a director of the Mississippi Hospital and Medical Service, Inc. Dr. Everett Crawford of Tylertown was appointed by the president to serve Dr. Hicks' unexpired term.

The president, president-elect, secretary-treasurer, speaker, vice speaker, and AMA delegates sit with the Board in all meetings. Officers of the Board of Trustees during 1967-1968 are Drs. John B. Howell, Jr., chairman; Lamar Arrington, vice chairman; and C. D. Taylor, Jr., secretary.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your Reference Committee is deeply impressed with the tremendous amount of business which is handled by our Board of Trustees and the devotion which these nine leaders have demonstrated in the work of our association.

In approving the annual report of the Board of

(Turn to page 393)



The President Speaking

'Worth Waiting For?'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

THERE WILL BE NO Title XIX program in Mississippi in 1968. A succession of events in the legislature, in the highest councils of state government, and in the understanding of the various professional organizations making up our health care team confirms this conclusion.

At the 100th Annual Session, the Board of Trustees reported its work in an effort to secure implementation of Title XIX to the House of Delegates. The appointment of a blue ribbon study commission by Governor John Bell Williams under authorities granted him by Senate Concurrent Resolution 129 has apparently given some impetus toward a realistic and workable program, but the commission has made the decision to conduct studies for as long as a year.

It is an open secret along the corridors of the capitol building that there will be a special session of the legislature in which Title XIX will figure prominently. But more than this is beginning to shape up as state government moves toward meeting its problems in health services.

Under the "Partnership in Health Act," more technically, the Comprehensive Health Planning and Public Health Service Amendments of 1966, the state is mobilizing its forces for health planning. As our House of Delegates has stated on more than one occasion, a searching reappraisal of our fragmented, uncoordinated programs of health care is urgently needed.

The State Hospital Commission, charity hospital, token vendor, and a host of health service programs scattered among a dozen agencies of the state make us a textbook example of duplication, disparities in service, and inequities upon both physician and patient when it comes to state health service programs.

While the association's disappointment over the failure of the state to face up to reality and enact a sound Title XIX program is keen, we must nevertheless view the mixed blessing in unsnarling the knots in existing programs. Perhaps then, Title XIX in Mississippi shall have been worth waiting for. ★★★

JOURNAL OF THE
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EDITORIALS

The Tragedy of Tetanus, The Totally Unnecessary Disease

I

Of all significant health hazards for which immunization is available, tetanus—the totally unnecessary disease—is one of the greatest. More than 300 Americans die each year from tetanus, and distressing as this grim statistic is, the cold fact remains that the toll of life could be much greater. Only about one in three Americans has received toxoid prophylaxis.

On the basis of incidence and mortality, tetanus cannot rationally be classified as a major health problem in the United States, but there are arguments against this, too. In the first place, good preventive medicine is not exclusively quantitative, because if it were, then quite a few of the conquered killers might still be around to make a showing in the mortality statistics. And as far as those hapless 300 Americans who die each year from the disease, there may as well be no other cause of death.

Any physician knows that the efficacy of this immunization procedure is not a matter for debate. Experience with the armed services in World War II proved conclusively that tetanus can absolutely be eliminated as a cause of death. It is a sad commentary upon us all to realize that most Americans wouldn't condone their automobiles going 50 miles beyond the time for an oil change while they beckon the grim reaper welcome by ignoring tetanus immunization. Like Pinocchio's father, Americans are cobblers whose children have no shoes.

II

In the recent decade 1956-1966, the State Board of Health records 157 cases of tetanus in Mississippi. Of these, there were 108 deaths, a mortality rate of 69 per cent. But the seven-out-of-10 gets worse in the context of 1966 and 1967. Two years ago, there were 14 cases with 12 deaths in the state, a mortality rate of 85 per cent. In 1967, the public health records reflect 10 cases with eight deaths, 80 per cent. Every single case was tragically unnecessary.

Studies by the American College of Surgeons show that the greatest segment of the unprotected population is made up of adults, because the younger generation is routinely receiving immunization. It was this segment of the unprotected that was targeted by a major public service program of the physicians of Alcorn County in the spring.

The Alcorn County Medical Club, an unofficial organization of physicians apart from the component medical society, made the decision to do something about the adult population in and around Corinth who were unprotected against tetanus. The physicians organized and coordinated their effort, and the mayor of Corinth proclaimed April 15 through May 8 as the official campaign period during which every unprotected adult should be immunized against tetanus.

Both the toxoid series and booster shots were offered without charge in the offices of private physicians during regular hours. In a working partnership, the Alcorn County Health Department furnished the toxoid. Emphasis in the program publicity, well carried out in the *Daily Corinthian,* was on encouraging women to receive the immunization, recognizing that many men had received it in the military service.

III

At the 100th Annual Session, the House of Delegates was unanimous in adopting Resolution No. 6, sponsored by the Central Medical Society, urging each component medical society and all members of the association to support statewide education and immunization against tetanus.

The resolution condemned passive immunization with equine and bovine antitoxin for the high incidence of associated serum reactions. Passive immunization with human immune globulin was held to be expensive and of brief, nonpermanent duration. The measure called for three doses of the toxoid as the proven measure of protection.

That the action of the House of Delegates has had an impact shows up in plans underway in a number of Mississippi localities where physicians are laying groundwork for education and immunization campaigns. County health departments will be willing partners in these vital service projects of local medical groups, component societies, and even individual physicians.

IV

And not to be overlooked is the opportunity for industry to perform a valuable service in offering this immunization to employees. The Committee on Occupational Health of the state medical association has long advocated this measure, pointing out that an employer has both opportunity and obligation in providing a safe work environment. Nor is this altogether altruistic, either, because he has a valid interest in preventing lost time and decreased productivity resulting from illness and disease.

The American Medical Association has endorsed industrial immunization programs, stating that "an employer should immunize his employees who, by reason of their occupation or job assignment, may be exposed to significant hazards against which immunization procedures are available." The policy statement is tailor-made for tetanus immunization.

Will another 300 among the 200 million Americans die of tetanus—tragically and needlessly—in 1968? Probably so, but it need not be. This is the opportunity and challenge of wiping out once and for all the totally unnecessary disease.—R.B.K.

Medicare Mystery: More Money or What?

A combination of factors affecting Medicare is at work, and the end result is, at the moment, unclear. That the costs of the hospital (Part 1-A) and medical (Part 1-B) programs have exceeded the optimistic forecasts made in 1965 by administration proponents is hardly surprising. Government programs ranging from dams to military bases to medical care have the common characteristic of being underpriced during the selling phase.

While about 700,000 senior citizens missed out on their chance to sign up for the Supplemental Medical Insurance under Part 1-B between Oct. 1, 1967, and April 1 this year, the total under the program increased to 18.6 million from 17.9 million. This is a growth rate to 95 per cent of the over-65 population, up from 92 per cent at the beginning of the open enrollment period.

It is also perhaps notable that in the same six months period, the Part 1-B premium went up a third to $4 per month, a move correctly predicted by the JOURNAL last year. Considering the number ignoring the enrollment opportunity and the growth rate of participation, the increased cost of the premium to seniors must have been of little consequence.

Rising costs of quality medical care, mostly in hospital aspects, comprise another factor interplaying in the complex Medicare equation. The premium increase was supposed to cover any miscalculations of the planners as well as the rise in care costs. In addition, the extra dollar per month is aimed at providing a cushion against further cost inflation in the immediate future.

A third and significant factor is the continuing growth of the over-65 population. The insurance actuaries tell us that the life expectancy of at least one of a husband-wife couple retiring at age 65 is now 21 years. By any measure, this adds up to a mounting population of senior citizens.

And totally apart from any increase in medical care costs, there will still be a higher velocity in dollar outflow for services, simply because medical science is finding new ways to increase human life.

So what does it all mean? The answer isn't clear, because the factors are not necessarily related to a sufficient degree warranting the flat assertion of more money. Such a conclusion would deny the possibility of gains in technological ef-

ficiency, further discoveries in drugs, new and successful "spare parts" for the human body in transplants and prostheses, and, of course, in improving methodology in financing medical care.

But let's leave one solid fact firmly established and crystal clear: The private pattern of medical care delivery and care organization is the nation's best bet for meeting the challenge of the future, both with senior citizens and all Americans. Because whatever may happen, any undesirable consequences will be substantially lessened under a private care delivery system.—R.B.K.

The Fat American

The fat American—and he is said to be 40 million strong—is giving us all trouble, to say nothing of himself. He is first and finally a medical problem of staggering proportion, and his excess avoirdupois is also becoming the basis for legal skirmishes and discussions of medical ethics. What's more, the fat American is increasing in natural occurrence, because as many as 50 per cent of our 200 million are believed to be above their "best" weight.

MacBryde, writing in the *Medical Clinics of North America,* wrestles pretty successfully, in the opinion of many authorities, with a working definition of obesity. He concedes that the determination is usually made with reference to standard tables for weight based on height, age, sex, and body build. He goes on to describe excessive accumulation of body fat without excessive body weight, discussing, of course, adiposity, and he describes excessive body weight without accumulation of fat as being neither adiposity nor obesity.

He concludes that a good working definition of obesity is "that bodily state in which there is excessive accumulation of fat in both the relative and the absolute sense." In a nutshell, adiposity plus overweight.

Kannel, Thomas, and McNamara, writing in *Medical Times,* describe the health hazards of obesity. They believe that any individual with 20 per cent or more overweight, as compared to the median weight for persons of like height and sex, courts these risks:

—A 244 per cent excess risk of sudden death.

—A better chance of ending up with angina pectoris by 86 per cent.

—A risk of diabetes 82 per cent above the norm.

—And a 71 per cent greater chance of coronary artery disease.

There is even a socioeconomic aspect to the fat American. In a study of 334 obese and 1,042 "normal" individuals. Irwin, reporting in one of the popular Public Affairs Pamphlets, discovered that almost 31 per cent of those in the lowest economic bracket were fat. In contrast, about a fourth of the middle economic group was overweight, and the highest economic group had only 14 per cent with excessive poundage. He postulates that it is mainly a matter of starch versus protein in the diet.

Recently, the author of the popular and controversial book, *Calories Don't Count,* was convicted on counts of 11 felonies and one misdemeanor. His nostrum was safflower oil capsules, and his trespass of the law was in promoting them—mislabeled and misleading—through his book.

The use of cardiac glycosides, thyroid hormones, diuretics, anorexiants, and laxatives—all at the same time—as treatment aimed at reducing the patient has been condemned by the American Medical Association. Then there is the absolutely nonscientific "drinking man's diet," mechanical gadgets, and other fool-the-fat gimmicks.

There is just no doubt about it: The Fat American is causing everybody a lot of grief, even though his unfortunate circumstance threatens him most of all.—R.B.K.

Six Candidates and Tax-supported Medicine

Within the week, Americans will know the beginning of the ballot to be marked in November when the 37th President of the United States will be chosen. There are six serious possibilities: Humphrey and McCarthy in the Democratic camp, Nixon, Rockefeller, and Reagan in the Republican circle, and Wallace alone as the most serious third-party challenger in half a century. The six are about evenly divided on public, tax-supported medical care for all as a "matter of right."

The Democrats are unanimous for it. Vice President Humphrey supported Wagner-Murray-Dingell, Forand, King-Anderson, and Medicare with a fervor difficult to describe. Sen. McCarthy has strong feelings in that direction, too, albeit that they are somewhat submerged under his zeal for total disengagement in Asia and the ending of the war in Vietnam under any circumstances.

The Republicans are somewhere between two-to-one and one-one-one across the public care spectrum. Governor Reagan is an avowed conservative in the classic sense, and he spent three years covering the nation as he fought enactment of Medicare. Former Vice President Nixon is on record against most of the Social Security legislation leading to Medicare, but his "new Nixon"

veneer tends toward a middle-moderate position. One can only speculate that his occupancy of the White House would be a slightly liberalized rerun of the Eisenhower years.

Governor Rockefeller can absolutely out-Humphrey Humphrey when it comes to tax-supported, compulsory medical care. He testified for expansion of Medicare to include every American before a committee of the Senate in May. He has been thoroughly consistent in seeking state compulsory health insurance in New York, a measure which even the Democrat-dominated Empire State legislature can't stomach, because his bill couldn't get out of committee in either house this session. He made another pitch for his goal at the spring governors' conference.

Governor Wallace leaves nothing for speculation as to his views on the role and responsibility of government in providing health care and other welfare services. Any discussion of his position is rhetorical.

Very few Americans will enter the voting booth in November with tax-supported medical care in mind, but the views of the candidates in this respect may be reliable indices to what might be expected of them in the White House.—R.B.K.

POSTGRADUATE CALENDAR

REGIONAL CONTINUING EDUCATION

Mississippi Regional Medical Programs, the University of Mississippi Medical Center, and local medical staffs throughout the state are joining forces in a new and completely individualized continuing education series this year.

Known as "Specialist of the Day" programs, the new concept was field-tested in a pilot series at Singing River Hospital in Pascagoula and Coahoma County Hospital in Clarksdale during the early spring. Both hospitals will continue with the programs during the 1968-1969 academic year. Dr. C. D. Whigham of Pascagoula and Dr. Robert R. McGee of Clarksdale handle local arrangements for their hospital medical staffs.

Most recent in the series was Clarksdale's July 2 program on complications during the postoperative period with Dr. Hilary Timmis, associate professor of surgery, as guest specialist. At local staff request, he spoke at 1 p.m. on peripheral vascular collapse in the postoperative period and at 3 p.m. on postoperative pulmonary complications. Case presentations and open discussion were scheduled at 2 and 4 p.m.

Any hospital medical staff in Mississippi may request an MRMP-UMC Specialist of the Day series by writing to Dr. W. O. Barnett, MRMP Continuing Education Coordinator, and UMC Postgraduate Education Chairman, at the University Medical Center in Jackson.

FUTURE CALENDAR

September 13, 1968

PERITONITIS SEMINAR

October 3-4, 1968

ARTHRITIS SEMINAR

November 8, 1968

CARDIOPULMONARY RESUSCITATION TRAINING COURSE

February 19, 1969

LEDERLE SYMPOSIUM

March 7, 1969

KIDNEY SEMINAR

March 26-28, 1969

CARDIOVASCULAR SEMINAR

AMA Schedules Ethics Congress

The Judicial Council of the American Medical Association has announced that the Second National Congress on Medical Ethics will be conducted at Chicago Oct. 5-6. The announcement was made by Dr. E. G. Shelley of North East, Pa., chairman of the council.

The first such national conclave was held in 1965. Dr. Shelley told the JOURNAL that "this year's program will be a practical consideration of ethical principles in everyday practice.

"It will run the gambit of question from relationships with ancillary personnel to the ethics of transplanting hearts and lungs," Dr. Shelley said.

Speakers scheduled to appear include Drs. Chauncey D. Leake, F. J. L. Blasingame, Irvine H. Page, Paul A. Freund, and J. Frank Walker.

The congress will be sited at the Drake Hotel, and attendance will be limited, according to the announcement.

PERSONALS

JAMES L. BALLARD, JR., of Tupelo has announced the opening of his offices at 810 Garfield where he will limit his practice to dermatology.

S. E. BETHEA of Hattiesburg has been selected by fellow townsmen as one of two Senior Citizens of 1968. He is a graduate of the University of Mississippi and the Tulane University School of Medicine. He has practiced at Hattiesburg for 48 years.

LEMANN H. BOUNDS has been elected president of the Meridian Symphony Society for the term extending until June 1969. He limits his practice to otolaryngology and is one of the founding members of his city's symphony society.

CURTIS W. CAINE of Jackson has returned from the Caribbean area, including the Dominican Republic, where he assisted in the organization of a new mobile medical clinic. Dr. Caine flew his own plane in the Central American area in the service project.

CHARLES E. CATCHINGS of Woodville has been honored by the U. S. Selective Service System in recognition of 25 years of uncompensated service as medical adviser for his local board. He has been presented with a certificate signed by the President of the United States and a gold lapel pin.

FRANK M. DAVIS and DEWITT HAMRICK of Corinth were recipients of Presidential certificates in recognition for 25 years services as medical advisers to their local board of the U. S. Selective Service. Each also received the honoree's lapel pin. Both physicians have served in high elective office in the Mississippi State Medical Association.

FRANK G. GARBIN of Ocean Springs has occupied his new clinic building at 1200 Washington Ave. He is a 1955 graduate of the University of Tennessee College of Medicine after which he received his postgraduate training at St. Joseph's Hospital at Memphis. He served in the U. S. Air Force as a medical officer prior to establishing his private practice.

J. HENRY HOLLEMAN of Columbus has announced the relocation of his offices in the Medical Arts Center at 221-7th St. North.

VERNER S. HOLMES of McComb served as co-chairman of the 3rd Congressional Caucus to the Mississippi Democratic Convention conducted last month at Jackson. He has served as president of the Board of Trustees of Institutions of Higher Learning.

JAMES M. HOWELL of Picayune is serving as physician to Camp Tiak, Pine Burr Area Council, Boy Scouts of America, during the summer camping season. Each Boy Scout receives an examination in the Pine Burr Area Council before acceptance at camp.

J. MANNING HUDSON of Jackson has been elected to the American College of Physicians. Candidates for ACP membership and fellowship must have completed approved residency requirements and be certified by the American Board of Internal Medicine or by the certifying board of a related specialty. Dr. Hudson limits his practice to internal medicine.

BEN B. JOHNSON of Jackson has been elected secretary of the Mississippi Kidney Foundation for the 1968-69 year.

H. J. KELLUM, SR., of Tupelo and Mrs. Kellum celebrated their Golden Wedding Anniversary last month. Dr. Kellum has been practicing for 50 years. The couple's six sons and 22 grandchildren were present for the anniversary occasion.

GEORGE D. LADNER of Jackson has announced the opening of his offices at Suite 302 of the Medical Towers, 440 E. Woodrow Wilson Drive. He limits his practice to psychiatry.

CARL G. NICHOLS, JR., of Leland has occupied his new clinic building at 206 Baker St., adjacent to his former location at 204 Baker St. The clinic was designed in the Williamsburg motif with cedar shingles and a mansard roof line.

GLEN T. PEARSON officiated at the induction of his brother, JOHN M. PEARSON, and another physician colleague, DAVID M. OWEN, into the Hattiesburg Rotary Club.

WILLIAM E. SEALE of Crenshaw (Panola County) retired from his practice last month and was honored for his more than half a century of service by the Crenshaw Baptist Church. He received his premedical education at Mississippi College and his M.D. from the former University of Louisville. He is a member of the Fifty Year Club.

A. JACK STACY of Tupelo has announced the association of JOHN M. BLAKEY in the practice of diagnostic and therapeutic radiology. Their offices are located at 114 Professional Building, 420 Main St.

JAMES L. THORNTON of New Albany has been

elected medical representative of the Union County Heart Association for 1968-69.

E. LeRoy Wilkins of Clarksdale has retired as chairman of the Coahoma County Welfare Board, a post which he has held for 30 years. Dr. Wilkins is a past president of the Mississippi State Medical Association and is the incumbent chairman of the Council on Constitution and By-Laws.

Cecil T. Williams, Jr., of Tupelo has announced the closing of his offices at 420 Main St. and his entry into residency training.

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

Becker, Jasper Benoit, Jr., Brookhaven. Born Brookhaven, Miss., Aug. 10, 1934; M.D., Tulane University School of Medicine, New Orleans, La., 1960; interned Charity Hospital of Louisiana, New Orleans, one year; urology residency, Ochsner Foundation Hospital, New Orleans, La., three years; residency, E. A. Conway Memorial Hospital, Monroe, La. one year; elected March 12, 1968 by South Central Mississippi Medical Society.

Farmer, Charles Emerson, Jr., Jackson. Born Lowndes County, Mississippi, Feb. 4, 1935; M.D., University of Mississippi School of Medicine, Jackson, 1959; interned University of Arkansas Medical Center, Little Rock, one year; general surgery residency, University of Arkansas Medical Center, Little Rock, four years; elected March 5, 1968 by Central Medical Society.

Hutchinson, Richard Glenn, Jackson. Born LaGrange, Ga., Aug. 18, 1933; M.D., Medical College of Georgia, Augusta, 1959; interned Baptist Hospital, Nashville, Tenn., one year; internal medicine residency, Medical College of Georgia, Augusta, three years; fellowship, Medical College of Georgia, Augusta, one year; elected May 7, 1968 by Central Medical Society.

Pugh, Glen Omar, Macon. Born Philadelphia, Miss., Jan. 10, 1930; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned University Hospital, Jackson, one year; elected June 11, 1968 by Prairie Medical Society.

Tyler, Henry Brown, Jackson. Born Drew, Miss., May 26, 1935; M.D., Johns Hopkins University School of Medicine, Baltimore, Md., 1961; interned Vanderbilt University Hospital, Nashville, one year; surgery residency, Peter Bent Brigham Hospital and Children's Hospital Medical Center, Boston, Mass., six years; elected May 7, 1968 by Central Medical Society.

Supreme Court Refuses to Recognize Alcoholism

By a 5-to-4 decision, the United States Supreme Court has refused to lay down a constitutional rule against punishing chronic alcoholics for being drunk in public.

In the opinion, Justice Thurgood Marshall and three other justices said that neither the facts of the test case nor the comparatively primitive state of scientific knowledge on the subject justifies such a decision at present. Justice Byron White concurred separately to carry the decision by a single vote.

The test case upheld the conviction of a Travis County, Texas, man for public drunkenness, although he was shown to be suffering from chronic alcoholism.

Two AMA authorities on alcoholism, Drs. Marvin Block of Buffalo, N. Y., and Dr. Dana L. Farnsworth of Harvard University, chairman of the AMA Council on Mental Health, expressed surprise and disappointment with the court's decision.

Dr. Farnsworth said that chronic alcoholics in general suffer from such an irresistible compulsion to drink and get drunk in public that they are utterly unable to control their performance.

DEATHS

Daniel, William Jackson, Jr., Fulton. M.D., University of Tennessee College of Medicine, Memphis, 1946; interned John Gaston Hospital, Memphis, Tenn., one year; died June 2, 1968, aged 55.

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

Military Surgeons Set Conclave

"Quantity and Quality in Medical Care" is the theme of the 75th Convention of members of the Association of Military Surgeons at Washington's Sheraton-Park Hotel, 21-23 October as announced by Dr. William H. Stewart, the AMSUS President.

This theme will be sounded by a galaxy of speakers and panelists, which includes Chiefs of the Federal Medical Services. The keynoter is Robert Q. Marston, M.D., whose address is titled, "The Several Paths to Quality."

Approximately 75 International Delegates will be honored at the International Convocation and Luncheon held at noon of the first day. The scientific program is particularly interesting and timely. A panel of experts will discuss "The Doctor of Medicine—A Critical Federal Resource," and will include moderator, George H. Reifenstein, M.D., Technical Director, Clinical Research and Medical Education, Naval Medical Center, Bethesda; and panelists, James C. Cain, M.D., Mayo Clinic, Rochester, Minn.; John S. Millis, Ph.D., Chancellor, Case-Western Reserve Univ., Cleveland; John Parks, M.D., Dean, George Washington Univ. School of Medicine, Washington; Oren T. Skouge, M.D., Veterans Administration, Washington; and R. T. Jenkins, Major General, USAF (Ret.).

Another panel concerned with "The Role of Allied Health Personnel in the Delivery of Health Services" will be moderated by Harold M. Schoolman, M.D., Director of the VA Education Service, Washington.

Louis C. Lasagna, M.D., Johns Hopkins School of Medicine, Baltimore, who will speak on "The Future of Clinical Pharmacology" has been selected this year's Sustaining Membership Lecturer.

The honor of presenting the William C. Porter Lecture in psychiatry this year goes to Morton G. Miller, M.D., Director, Division of Special Mental Health Programs, NIH, Bethesda. The title of Dr. Miller's lecture is, "The Problem of Drug Abuse: Alienation and the 'Alienist.' "

Over 115 technical and scientific exhibits will be on display; and medical films, submitted in competition for a prize, will run throughout each day. A specially prepared program will entertain the wives of visiting members.



Dr. Cottrell Is Named State Health Officer, Dr. Morgan Is New Deputy

Dr. Hugh B. Cottrell, a native of Holmes County, has been appointed state health officer by the State Board of Health. The appointment became effective July 1. Dr. Cottrell succeeds the late Dr. A. L. Gray who died March 4.

Dr. Frank J. Morgan, Jr., who served as acting state health officer after Dr. Gray's death, was named assistant state health officer with tenure beginning concomitantly with that of Dr. Cottrell. He was formerly executive assistant to Dr. Gray.



Dr. Cottrell

The board acted at its regular semi-annual meeting in late June in making the appointments to the two high offices.

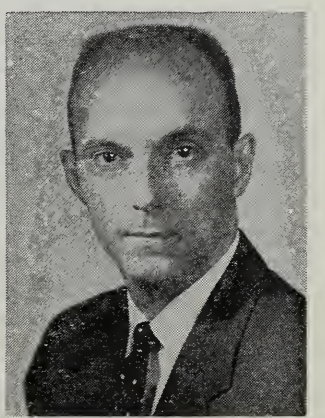
Dr. Joseph G. McKinnon of Hattiesburg, president of the State Board of Health, said that the state agency "is exceedingly happy to have the services of Dr. Cottrell as state health officer, and we are happy that the services of Dr. Morgan will be retained as assistant state health officer.

"The State Board of Health feels that Dr. Cottrell will amply fulfill the duties and obligations of the office, and we are happy to welcome him back to his native state," Dr. McKinnon said.

In assuming his duties as Mississippi's fourth state health officer, Dr. Cottrell returns after an absence with the United States Public Health Service of 18 years. He resigned from his work in the state in 1950, and he spent all but six years with the Atlanta regional office of USPHS.

In 1962, he became health director for Region IV of the Public Health Service, working with Mississippi and five other southern states. He is recently remembered as the public health project officer in the crisis near Natchez when the chlorine-laden barge sank in the Mississippi River. The deadly gas cylinders were safely raised without injury or loss of life.

Dr. Cottrell was born at Pickens, attended the public schools at Vicksburg, and received his premedical education at Millsaps College. He was graduated in the class of 1932 from the Tulane University School of Medicine and received his initial postgraduate training at the U. S. Public Health Service Hospital at Norfolk, Va.



Dr. Morgan

In 1935, he was awarded the Master of Public Health degree by the Johns Hopkins University. Dr. Cottrell is a diplomate of the American Board of Preventive Medicine.

Over a period of 17 years, the newly designated state health officer was a staff member of the Mississippi State Board of Health. He began this phase of his career as supervisor of the field unit and participated in the organization and reactivation of 48 county health departments. At one time or another, he was county health officer for 26 local units.

Counties in which Dr. Cottrell served as local health officer include Amite, Benton, Calhoun, Carroll, Claiborne, Clarke, Copiah, George, Greene, Grenada, Holms, Jasper, Lauderdale, Madison, Marion, Noxubee, Perry, Rankin, Scott, Simpson, Smith, Stone, Tippah, Union, Wayne, and Wilkinson.

His most recent assignment in the USPHS was at the National Communicable Disease Center at Atlanta where he was assistant to the chief for medical liaison. Dr. Cottrell has recently com-

pleted a term as president of the Southern Branch of the American Public Health Association which encompasses 16 southern states.

He is additionally a member of the American Medical Association, the American College of Preventive Medicine, and APHA.

Dr. Morgan, the newly appointed assistant state health officer is a native of Meridian. He attended Ole Miss and Cornell University, later receiving his M.D. degree at the Tulane University School of Medicine. He completed his internship at New Orleans Charity Hospital and a five year residency in general surgery at Mercy Hospital at Vicksburg and the University Medical Center.

During 1949-51, Dr. Morgan was on active duty with the U. S. Navy as a flight surgeon and was decorated for meritorious service in the Korean War. He presently holds the grade of commander in the Naval Reserve Medical Corps.

Prior to coming to the State Board of Health as executive assistant to the state health officer in 1966, Dr. Morgan served six years as director of the tri-county health district made up of Forrest, Perry, and Lamar counties.

He has also served as director of the Delta Pilot Project, a maternal and infant care activity, and has held administrative responsibility for the State Board's radiological health unit as well as the medical and health defense unit.

Crowley, Malone Are Named by MHA

T. W. Crowley, administrator of King's Daughters Hospital in Brookhaven, is the new president of the Mississippi Hospital Association, following its 37th annual convention in Biloxi.

Crowley succeeds Daniel Watson, administrator of the Montfort-Jones Memorial Hospital in Kosciusko, who presided at the three-day meeting on the Mississippi Gulf Coast.

Richard H. Malone, administrator of Hinds General Hospital in Jackson, was chosen as the new president-elect of the statewide organization of hospital administrators.

Highlight of the closing session was passage of a resolution asking the state college board to meet with representatives of MHA and of the Mississippi Nurses Association about nurse education.

The resolution cited the need for upgrading the state's nurse-education programs, with particular emphasis on establishment of a Master's Degree Program in nursing education.

The already-serious nurse shortage is aggravated, said the resolution, by a high rate of failure of graduating students to pass official state examinations.

Estimates of the rate of failure range from 37 to 50 per cent. Charles W. Flynn, director of the Mississippi Hospital Association, said ill-prepared faculties are one cause of the many state examination failures.

The MHA resolution urged that "no new or additional nursing education programs be approved" until present programs are upgraded, but this sentence was eliminated during discussion.

Tom Logue, administrator of Tallahatchie General Hospital in Charleston, urged deletion of the sentence, arguing that the need for nurses is too pressing to cut off proposed new programs.

The delegates also approved a resolution calling for use of standardized claim forms for all third-party pre-payment plans, at both the state and national level, in order to reduce administrative costs.

In other resolutions, the Mississippi Hospital Association:

. . . offered assistance to the State Division of Comprehensive Health Planning "in determining appropriate boundaries for area-planning activities and in fostering establishment of voluntary area-wide planning agencies."

. . . urged hospitals to participate in the Mississippi Regional Medical Program "as focal points through which many of the program's objectives for heart, cancer, stroke and related diseases will be carried out."

. . . called upon hospitals not presently nationally-accredited to expedite plans for achieving such accreditation.

. . . praised Dr. David B. Wilson, director of University Hospital in Jackson, for his election as president of the American Hospital Association—the only Mississippian ever to hold the post.

A testimonial dinner honoring Doctor Wilson was a feature of the convention. Doctor Wilson urged hospitals to "join hands in partnership with all health agencies and all health personnel, for the good of community health."

Two portraits were unveiled at the testimonial dinner—one of Doctor Wilson, the other of Bishop Joseph B. Brunini, Diocese of Natchez-Jackson, who was president (1956-57) of the Catholic Hospital Association of the United States.

Both portraits will be hung in the lobby of the new MHA headquarters building in Jackson.

Speakers for the three-day meeting included the following:

Richard G. Allen, associate professor, School

of Health Services Administration and director of the Center for Continuing Education at the University of Alabama Medical Center in Birmingham.

Dexter Kimsey, program consultant, Office of Comprehensive Health Planning, U. S. Public Health Service, Atlanta, Georgia.

Duane T. Houtz, administrator of the Medical Center, Birmingham Baptist Hospitals, Birmingham.

J. Q. Monaghan, medical licensing field representative for the Mississippi State Board of Health, Jackson.

Thomas M. Tierney, director, Bureau of Health Insurance, Social Security Administration, HEW, Baltimore, Maryland.

Allen urged hospital administrators to take more responsibility toward formalizing programs for the continuing education of their personnel.

Houtz outlined basic steps which should be followed by the administrators in setting up programs to meet disasters.

Kimsey described ideal goals for state programs for comprehensive health planning. Such a program will get under way soon in Mississippi.

Monaghan said use of illicit drugs is on the rise in Mississippi, but abuse of legal drugs remains the state's major narcotics problem.

Tierney said Medicare, since July 1, 1966, has paid $33,500,000 to Mississippi hospitals and $11,600,000 to Mississippi physicians.

The convention ended with installation of Crowley as president and with the announcement of the election of the following to other posts:

Charles N. Payne, Jr., Laurel, administrator, Jones County Community Hospital, Laurel, MHA delegate to American Hospital Association.

D. A. Lingle, administrator, King's Daughters Hospital, Greenville, alternate AHA delegate.

Chandler Clover, administrator, Doctors Hospital, Jackson, Speaker of the MHA House of Delegates.

Nolan H. Dees, Jr., administrator, Laurel General Hospital, Laurel, and Obie L. Freeman, administrator, Lumberton Citizens Hospital, Lumberton, to three-year terms on the MHA board of governors, and Billy D. Martin, administrator, Franklin County Hospital, Meadville, to a two-year term.

Members of Mississippi Affiliates, American College of Hospital Administrators, elected officers including Lester L. Tuck, administrator,



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Singing River Hospital, Pascagoula, president; Richard H. Malone, administrator, Hinds General Hospital, Jackson, vice-president; Charles N. Payne, Jr., Laurel, administrator, Jones County Community Hospital, Laurel, secretary-treasurer. Elected to the board were Sister Josephine Therese, OP, administrator, St. Dominic's Hospital, Jackson, and Roy Myers, administrator, General Hospital, Greenville.

Named to the board of directors of Mississippi Hospital and Medical Service (Blue Cross-Blue Shield) for three-year terms were Earl Grimes, Jr., administrator, King's Daughters Hospital, Yazoo City; Robert A. Ivy, administrator, Doster Hospital, Columbus; Paul J. Pryor, administrator, Mississippi Baptist Hospital, Jackson; and Sister Josephine Therese, OP, St. Dominic's Hospital, Jackson.

The 1969 convention will be held in Biloxi.

LBJ Makes Sweeping HEW Reorganization

President Johnson has pushed the reorganization of the Department of Health, Education, and Welfare further with additional changes, the JOURNAL has learned. He has designated HEW Secretary Wilbur J. Cohen as the chief federal officer for health policies and programs in the administration.

As outlined by the President, Secretary Cohen will be:

—The President's chief adviser on federal health policy and programs.

—Responsible for coordinating all federal health programs.

—Head of the newly created Federal interdepartmental Health Policy Council.

The reorganization also included creation of a Consumer Protection and Environmental Health Service as a unit of the U. S. Public Health Service.

A more sweeping move was the transfer of the Division of Regional Medical Programs from the National Institutes of Health to the Health Services and Mental Health Administration.

The President is said to be planning to ask the Congress to raise the status of HEW's principal health official, now Dr. Philip R. Lee, from assistant secretary to undersecretary for Health and Science.

The new consumer and environmental health unit heads these familiar agencies, some of which were previously independent:

—The Food and Drug Administration.

—The National Center for Air Pollution Control.

—The National Center for Radiological Health.

—The National Center for Urban and Industrial Health.

—And certain staff units of the Office of the Director of the Bureau of Disease Prevention and Environmental Control.

Heading the new unit will be Charles C. Johnson, Jr., a Negro and Assistant Commissioner for Environmental Health of New York City. He is an engineer, and his new post will make him the highest ranking member of his race in the history of the U. S. Public Health Service.

Dr. Herbert L. Ley, Jr., director of the FDA's Bureau of Medicine since 1966, was named by President Johnson to succeed Dr. James L. Goddard who recently resigned as Commissioner of Food and Drugs.

The reorganization also reposes new authorities in HEW in overseeing all federal activites in the health field, including the drafting of physicians for military service, supervision of Veterans Administration hospitals, and Office of Economic Opportunity health projects.

Secretary Cohen said that control of the doctor-draft will enable HEW to assure that sufficient physicians are available in civilian life to provide for needs of all citizens. He said that he is opposed to drafting doctors to care for civilian dependents of those in the military and that this task should be undertaken by private physicians.

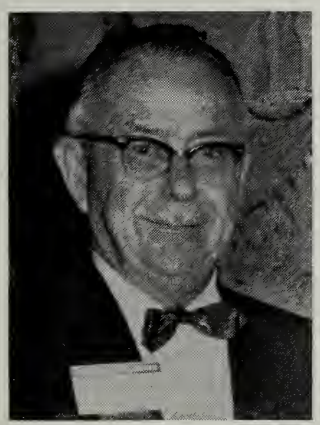
Cohen was quoted as saying that "this allocation of a portion of the critically scarce physician pool materially affects programs intended to make health care as widely available as possible, a national health goal which goes far beyond the mission of the Department of Defense."

Cohen was also quoted as stating that "physicians must act with restraint on fees or people will ask the government to put on controls, and I would not like to see that."

The sweeping reorganization is already in progress, and transfer of various health-related departments to HEW control is expected to be complete by Sept. 1, the JOURNAL learned.

Dr. Howell Is Named Vice Speaker

Dr. James L. Royals of Jackson, president-elect of the Mississippi State Medical Association, has resigned his post as vice speaker of the House of Delegates following his election to the number two office at the 100th Annual Session.



Dr. Howell

Dr. John B. Howell, Jr., of Canton has been named by President Joseph B. Rogers to serve Dr. Royals' unexpired term as the second ranking presiding officer of the House. The term extends until 1970.

Dr. Howell, a longtime leader in association affairs, served on the Board of Trustees from 1955 until 1968 when he retired after the constitutional maximum of consecutive terms. He was vice chairman of the Board for three years and chairman for four years, from 1964 through 1968.

He has been president of the Mississippi Academy of General Practice and now serves as delegate to the AAGP from Mississippi. He has assumed his new duties and will share responsibilities for presiding at the 101st Annual Session with the speaker, Dr. William E. Lotterhos of Jackson.



Dr. Royals

Dr. Royals is past secretary-treasurer of the association and served three years as chairman of the Council on Scientific Assembly. He currently serves as the association's representative on the Regional Advisory Body of the Regional Medical Program. He will be inaugurated president at the May 12-15, 1969, annual session at Biloxi.

Both Drs. Royals and Howell are among the general officers who regularly sit with the Board of Trustees. These include the president, president-elect, secretary-treasurer, speaker and vice speaker, and the delegates to AMA.

Dr. Tatum Is Appointed to Education Council

Dr. Frederick E. Tatum of Hattiesburg has been appointed a member of the Council on Medical Education to serve the unexpired term left vacant by the resignation of Dr. R. Mayo Flynt of Meridian. The appointment was announced by Dr. Joseph B. Rogers of Oxford, president of the association who said that the term will extend until 1970.

Dr. Tatum joins Dr. William O. Barnett of Jackson, chairman, and Dr. Dennis E. Ward of Corinth as a member of the key constitutional group. As with other elected councils, membership automatically qualifies incumbents as voting members of the House of Delegates.

The Council on Medical Education recently completed a massive study of postgraduate and continuing medical education in Mississippi, and the study report and recommendations of the council were approved by the House of Delegates.

Expressing satisfaction over Dr. Rogers' appointment of Dr. Tatum, Chairman Barnett said that the council will be chiefly concerned during the 1968-69 association year with seeking implementation of the study recommendations and in organizing a permanent program of continuing education for Mississippi physicians.

Dr. Tatum is a graduate of Millsaps College and the University of Tennessee College of Medicine. He received his postgraduate training at Wesley Hospital in Chicago and at the John Gaston Hospital at Memphis. He limits his practice to internal medicine, and he has been a leader in the Mississippi Society of Internal Medicine and the Mississippi Heart Association.

UMC Will Offer Elective Choice

University of Mississippi School of Medicine seniors will this fall register for the first elective program offered at the University Medical Center.

Part of an ongoing curriculum re-evaluation begun several years ago and partially financed by the National Fund for Medical Education, the new program will help cut down the amount of didactic time spent in the classroom and allow greater flexibility in the Center's education program.

One-sixth of the senior class registering in September will be assigned to a six-week elective

bloc during each six-week period in the academic year. Following the first six-week rotation, a second group of 12 students will join the program.

Both clinical and basic science departments will offer electives, some to be departmental and others to be arranged on a completely individualized basis as requested. All elective courses, to be designated by a single number, will be included in the 1968 Bulletin.

Dr. Craven Publishes Hospital Accounting Work

An Ole Miss professor has published a new and important work on hospital accounting resulting from cost-finding requirement of Medicare, Public Law 89-97. Dr. Albert L. Craven, Jr., formerly of Clinton, has released the work which was completed as a doctoral dissertation at the University of Alabama Graduate School.

The book, *Impact of Cost Finding Requirements of Medicare Legislation on Hospital Accounting and Cost Control,* was assisted by grants from the Mississippi Research and Development Center and the University of Mississippi Committee on Faculty Research.

Dr. Craven, a member of the Ole Miss faculty in the school of commerce, was formerly a professor at Mississippi College. His area of professional interest is accounting, and he is also a certified public accountant.

The work has as its objectives an historical review of the development of hospital accounting procedures, examination of problems implicit in implementing Medicare cost-finding requirements by hospitals, evaluation of the impact of these requirements on Mississippi hospitals, and a study of the status of hospital accounting after the first full year of the Medicare program.

The 200-plus page treatise is expected to become a valuable technical reference for those in hospital cost accounting and to the accounting profession.

RMP Adds New Staff Members

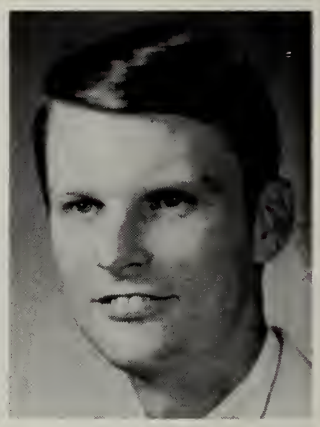
Two additional staff members have been named for Mississippi Regional Medical Programs headquartered at the University Medical Center.

Dr. William O. Barnett, professor of surgery at the medical center, will serve as postgraduate education coordinator for MRMP. Dr. Barnett has headed the University of Mississippi School of Medicine postgraduate education committee since 1965.

Dr. T. D. Lampton has been named heart and stroke categorical coordinator for MRMP and is also an instructor in medicine. Dr. Lampton returned to the medical center from Birmingham where he was a staff physician with the Alabama State Board of Health. He was graduated from the University of Mississippi School of Medicine in 1962 and took residency training at the medical center.

UMC Accepts 24 New Interns

Twenty-four newly graduated physicians began their internships at University Hospital in Jackson July 1, among them the top scholar of the University of Mississippi School of Medicine Class of 1968, Dr. William A. Causey of Jackson.



Dr. Causey

The interns come from three schools: University of Mississippi, Baylor University College of Medicine and the University of Texas Southwestern Medical School. Dr. James Strong of Baylor is a rotating intern as is University of Texas graduate Dr. Michael Bertino. Dr. Charles Younger, who also earned the M.D. degree at Texas, will do a straight surgery internship.

Straight medicine interns who are Mississippi graduates include Doctor Causey, Dr. Wilford Patterson, Dr. Roderick Ward and Dr. Benjamin Wells. Dr. Glenn Girod and Dr. Dennis Wright, both UMC graduates, are straight pediatrics interns.

Others from the University Medical Center who will intern at University Hospital include: straight surgery: Dr. Rudolph Branch; rotating: Dr. John Akers, Dr. Bert Bradford, Dr. Park Chittom, Dr. James Grace, Dr. Stanley Hartness, Dr. Lewis Hatten, Dr. Fred Ingram and Dr. Lucas Platt. Also, Dr. Robert Rester, Dr. George Robinson, Dr. Pervie Simpson, Dr. John Sumners, Dr. William Tompkins and Dr. William Warfield, all of the Class of 1968.

(Continued from page 377)

Trustees which largely consists of referrals from the House of Delegates at the 99th Annual Session, we ask the House to associate itself with the reference committee in expressing appreciation to the Board for its continuing, effective service to Mississippi medicine.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "A" OF THE BOARD OF TRUSTEES

Proposed Amendments to the By-Laws: Journal MSMA. With a single exception, the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION is furnished to all members, regardless of degree of membership, as a benefit. In addition to active, dues-paid members, this includes active members exempt from dues, Emeritus members, and Associate members. The single exception are those exempt from dues when called to active service in a component of the armed forces, and this classification may be furnished the JOURNAL only upon payment of subscription fees.

> This limitation is prescribed in Section 4(c), Chapter I, of the By-Laws which states in part that "a member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from military service; receipt of publications of the association during such period shall be at the expense of the member."

This provision was placed in the By-Laws about the time of the Korean War when a portion of dues was applied to the member's subscription. Since that time, and until the present Vietnam War, few members were called into service, and the association has also begun publication of the JOURNAL. The present doctor-draft demands require about 24 members per year to be in service, and it seems unfair to your Board of Trustees to require these members to pay for the JOURNAL. It can be furnished at insignificant expense to the association, and it is recommended that the final clause of the sentence quoted be deleted.

Election of Officers. The method and procedures prescribed in the By-Laws for the election of officers has not been changed in 50 years. Examination of the By-Laws published in the 1918 Transactions discloses that Chapter VI requires organization of the Nominating Committee by association districts on the first day of the annual session, the consultation and nomination process, and balloting on the final day of the meeting.

> The urgent and critical need for the best possible leadership and the undesirable, outdated procedures by which our leaders are selected require substantial change.

Three objectives appear necessary and desirable in the representative process of selecting those who will lead our association:

(1) Encouraging participation in the selection or nomination process by every member of the association.

(2) Securing nominees who possess the highest possible qualifications for office.

(3) Securing nominees who will agree to serve, if elected.

Experience has demonstrated that completion of the ballot under pressures of the annual session is sometimes an arbitrary process, and there are occasions when a member is nominated for office with the understanding that he will withdraw, leaving the House of Delegates no choice as to who will serve. Accordingly, the Board of Trustees recommends that Section 2, Chapter VI, By-Laws of the Association, be repealed and the following substituted therefor:

Section 2. Nominations. The House of Delegates, at the adjourned meeting of the annual session, shall select a Nominating Committee consisting of nine members of the House, one from each association district and each eligible to serve as a member of the House at the next annual session. Selection of committee members shall be made in district caucuses, and the committee shall elect its chairman. It shall be the duty of the committee to consult with members of the association through their respective component medical societies; to consult prospective nominees for office as to their willingness and ability to serve, if elected; to conduct a formal meeting at least three months prior to the annual session at which elections are to be held and to agree upon a slate of nominees at this meeting; and to publish to the membership this slate of nominees not later than one month prior to the next annual session. The committee shall nominate to the House of Delegates three members for each general officer vacancy and two names for all other offices. No two candidates for President-elect shall be named from the same county. Nominations for appointment to membership on the Mississippi State Board of Health shall be made in accordance with Section 7024, Mississippi Code of 1942, Recompiled, provided that six names shall be submitted, three of whom shall be elected and their

names submitted to the Governor as nominees from each public health district, provided that no member shall be nominated who has served two consecutive terms. Five members shall be nominated for a vacancy occurring on the Board of Trustees of Mental Institutions which nomination shall be submitted to the Governor in accordance with law.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your council received two proposed amendments to the By-Laws from our Board of Trustees. So that these may be voted upon as separate entities, your reference committee will report on these proposals *ad seratim.*

The Board proposes an amendment to Section 4(c), Chapter I, of the By-Laws which states in part that "a member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from the military service; receipt of publications of the association during such period shall be at the expense of the member," by deleting the last clause.

This portion of the By-Laws was adopted during the Korean War when the association was required to dedicate a portion of each member's dues for purchase of the official scientific publication of the association. Now that we publish our own JOURNAL, we are in position to furnish this service to exempt members at an insignificant cost, and the Board feels that it is unfair to deny members of the association in the military service their JOURNAL when all other exempt members receive the JOURNAL without cost.

Your council, therefore, recommends that the amendment to the By-Laws as proposed by the Board of Trustees be adopted.

The Board of Trustees has also recommended that Section 2, Chapter VI, By-Laws of the association, be repealed and that a new section providing for a Nominating Committee selected in district caucuses by this House of Delegates at the conclusion of the annual session be adopted. The Nominating Committee would conduct formal meetings at least three months prior to the annual session at which elections are to be held and agree upon a slate of nominees at this meeting and publish this slate of nominees to the membership of the association not later than one month prior to the annual session at which the balloting and selection will occur.

Your council believes that there should be no limitation upon nominations for the State Board of Health as to the maximum number of terms of consecutive service, and, therefore, we recommend that the proposal by the Board of Trustees be adopted with the deletion of that portion of the amendment which reads "provided that no member shall be nominated who has served two consecutive terms." As changed, your council recommends that this amendment to the By-Laws be adopted.

The report of the council, acting as a reference committee, was adopted.

SUPPLEMENTAL REPORT "B" OF THE BOARD OF TRUSTEES

Proposed New Component Medical Society: Authority for Organization. Section 1, Chapter XII, By-Laws of the association states in part that groups of physicians "which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Board of Trustees and approval by the House of Delegates, receive a charter from and become a component part of this association." Twice in the past 15 years, groups have so applied to the Board, and after approval by the House of Delegates, have been chartered component medical societies. The method of application is by petition of physicians in each county concerned.

Jackson County Petition. The Coast Counties Medical Society consists of Hancock, Harrison, Jackson, and Stone counties. The physicians of Jackson County, now about 50 in number, feel that because of localization of professional activities with excellent hospital facilities and the geographic factor making attendance upon meetings at the western extreme of the Gulf Coast difficult, a separate component medical society is desirable.

> On April 4, 1968, the Board of Trustees formally received a petition from 39 physicians in Jackson County requesting approval of a new society in that county to be known as the Singing River Medical Society. The petition is in order and has been approved by the Board of Trustees.

Approval Action. The Board of Trustees recommends that the House of Delegates approve the organization and chartering of the Singing River Medical Society under the provisions of Section 1, Chapter XII, By-Laws of the association. Because of the fiscal and membership year, the official charter date should be January 1, 1969.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Under the By-Laws of the association, 39 physicians in Jackson County have petitioned the Board of Trustees for the approval for organization of a new component medical society. The petition is in order and the board has approved the application of the physicians in Jackson County recommending that the Singing River Medical Society be chartered on January 1, 1969.

Your Reference Committee notes that the Coast Counties Medical Society, in which Jackson County is presently located, has endorsed the application of these physicians for a new component medical society. Your Reference Committee approves the recommendation of the Board of Trustees noting that all applicable portions of our constitution and By-Laws have been observed in this procedure. We therefore recommend that the Singing River Medical Society be chartered by the Board effective January 1, 1969.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "C" OF THE BOARD OF TRUSTEES

Study of Postgraduate Education in Mississippi: The Board of Trustees commends to the House of Delegates the study report of the Council on Medical Education, "Profile of Attainment—Measure of Need," and its probing and comprehensive review of postgraduate or continuing medical education in Mississippi. The Board also transmits with its approval the report of the council containing four recommendations growing out of the study.

In asking that the House of Delegates associate itself with the Board in approving the study report and recommendations, the Board commends and applauds the Council on Medical Education for the successful completion of this massive study and for providing valuable information which will usefully guide the association and all concerned with postgraduate education of physicians in Mississippi.

Organization and Background. Your Council on Medical Education is a constitutional body of the House of Delegates, responsible to the Board of Trustees. During the 1967-68 association year, your council has consulted with or reported to the Board of Trustees on four occasions.

> At the 1967 summer meeting of the Board, your council reported its belief of the need to intensify and improve postgraduate or continuing medical education for practicing physicians. We pointed to many recent national studies and to the overwhelming documentation of this need at every level of American medicine. We stated to the Board that "the case for innovation, direction, organization, and convenience in postgraduate medical education is supported by this need."

The Board approved your council's initiating discussions with the University Medical Center, the State Board of Health, and other appropriate agencies and organizations with a view toward finding areas of concurrence, mutuality of goals, and a plan for a useful postgraduate education program in Mississippi. It was also understood that the Board would be asked to consider such a plan in late 1967.

Study Proposal. Your council conducted these discussions in addition to its meetings and reported to the Board of Trustees at its winter meeting in December 1967. Based upon its preliminary findings, the council recommended that a major study and research project be authorized with a view toward:

—Assessing and defining the true dimensions of the problem as it exists among medical practitioners in Mississippi.

—Measuring the professional attainment of the practicing profession in Mississippi.

—Evaluating existing programs of postgraduate medical education as to adequacy and effectiveness.

—Examining in depth the individual desires, concepts of personal need, and instructional preferences of Mississippi physicians as to postgraduate medical education.

—Determining a concensus as to postgraduate medical education from the viewpoint of the several specialties.

—And integrating these data of new information, broadened knowledge, and current definitions into a pertinent and timely interpretation to guide the development of a realistic postgraduate or continuing medical education program of maximum effectiveness for the medical profession of the state.

Your council presented a detailed study prospectus in these connections, and the Board of Trustees approved the project. The Board also approved your council's receiving financial assistance from the Regional Medical Program for certain aspects of the study. The study has been completed, and the report has been transmitted to the Board of Trustees and to the House of Delegates.

Study Report. We have entitled our report "Profile of Attainment—Measure of Need." The

project actually includes four studies: The first is the profile of professional attainment; second, the survey of physician preferences and estimates of personal need; third, a study of formal and continuing postgraduate medical education opportunity in Mississippi; and fourth, a review of major national studies in this area. There is a chapter on each in the study report, in addition to a chapter on a proposal growing out of the findings and conclusions.

> For convenience, we have summarized our 23 findings and conclusions in Chapter 1 of the study report. We encourage all to read the entire report critically and to study carefully the valuable arrays of data. At the present date, the report has been distributed only to the Board of Trustees and House of Delegates. Your council recommends that a condensed version be published in serial form of three or four parts in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION at the earliest possible time.

Recommendations. Recognizing that the study report, as a serious research endeavor, may be widely circulated, your council made no recommendations in it, confining ourselves to findings and conclusions. Based upon our studies, your council makes the following recommendations to the Board of Trustees and House of Delegates:

(1) It is recommended that the Mississippi State Medical Association view the organization and implementation of an effective program of postgraduate or continuing medical education for practicing physicians of the state as a priority need and challenge.

(2) It is recommended that in any program which is developed that full and complete consideration be given the individual wishes and concepts of personal need as expressed by Mississippi physicians as to their preferences for instruction, program organization, and level of presentations and courses.

(3) It is recommended that the Mississippi State Medical Association, through the Council on Medical Education and the Board of Trustees, secure, possess, and exercise an active voice in the planning, organization, and management of postgraduate medical education in Mississippi.

(4) It is recommended that the association endorse and support the organization of a Mississippi Postgraduate Medical Institute with permanent facilities and staff as an adjunct to the University Medical Center. It is recommended that the Institute develop curricula, make use of medical center resources as necessary, and extend its services into local medical communities through improved circuit courses. It is recommended that the Institute offer a variety of on-campus training, tailored to the desires and needs of practicing physicians and that those who desire it, be offered the services of a faculty adviser in postgraduate education programs. In addition to the state medical association's active voice in all aspects of the Institute, it is recommended that the State Board of Health also possess a voice, because of its interest in and involvement with the health of all citizens.

Expression of the Council. Although your council listed the Board of Trustees first in its acknowledgements of appreciation in the study report, we restate this appreciation again for the guidance, support, backing, and encouragement which the Board has given in generous measure in this substantial endeavor.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your Reference Committee believes that the Council on Medical Education and the Board have made a landmark contribution to the matter of continuing education for practicing physicians in Mississippi. The study, Profile of Attainment —Measure of Need, has been furnished to all members of the House of Delegates and to all general officers and board members. The council has advanced four recommendations which include placing priorities on the matter of continuing medical education for practicing physicians, development of the program with full and complete consideration for the individual wishes and concepts of personal need as expressed by physicians, the securing and exercising of an active voice by the Mississippi State Medical Association in the planning, organization and management of postgraduate medical education in Mississippi, and the organization of a Mississippi Postgraduate Medical Institute which will offer continuing education to practicing physicians.

We commend the Council on Medical Education and all who were associated in this massive study endeavor and we approve the report of the Board of Trustees and Council on Medical Education with reference to the program. We recommend its adoption by the House of Delegates.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "D" OF THE BOARD OF TRUSTEES

Blue Shield: Background. The issue of Blue Shield has continually been before the House of

Delegates and Board of Trustees since 1964. It has been the subject of resolutions in 1964, 1965, and 1966 and of formal reports from the Board during the past three consecutive annual sessions. The issue has been the subject of one of the most substantial studies undertaken by the association, and it has occupied as much as half of the time of Board meetings which occur with a frequency of six to nine times annually.

> Through 1966, the Board held to a conservative position, and at the 98th Annual Session, the Board requested that the House of Delegates grant it a year during which conferences and negotiations might continue with the Mississippi Hospital and Medical Service, Inc.

At the 99th Annual Session in 1967, the House of Delegates adopted the following position:

> "The Board states that it is not satisfied with the accomplishments realized during the year which was granted by the House of Delegates. Your reference committee approves the findings and recommendations of the Board of Trustees and recommends that the House of Delegates of the Mississippi State Medical Association withdraw its approval of the Mississippi Hospital and Medical Service as a Blue Shield Plan if further improvement is not forthcoming. We further recommend that the association authorize the Board of Trustees to proceed to apply to the National Association of Blue Shield Plans for a charter and use of the Blue Shield symbol and proceed to implement a program when feasible under the auspices of the Mississippi State Medical Association, if we do not receive further improvements."

Conference With NABSP. Immediately following the 99th Annual Session, the National Association of Blue Shield Plans offered its services on request of the association, and a special meeting of the Board was conducted on June 29, 1967. Seven of the eight physician-directors of the plan who are not Trustees or officers attended on invitation of the board, as did one physician who represents hospitals on the plan's board of directors.

The association asked NABSP for advice after carefully reporting in detail the full succession of events over the preceding three years as regards Blue Shield in Mississippi. NABSP advanced and recommended a compromise proposal containing six points:

(1) Effect a definitive separation of Blue Cross and Blue Shield in Mississippi by having separate corporations for each.

(2) Separate boards of directors for Blue Cross and Blue Shield, with the state medical association participating in the election of Blue Shield directors.

(3) Separation of Blue Cross and Blue Shield funds, which means two separate treasuries, with each plan self-sustaining.

(4) Separate Blue Cross and Blue Shield contracts or a single contract with Blue Cross and Blue Shield benefits and dues (premiums) separately and distinctly identified.

(5) In view of capable management and a high level of staff people in the present plan, give consideration to having a single management who reports to the two separate boards of directors.

(6) Development of Blue Shield benefits on the "usual and customary" fee basis with the close cooperation of the state medical association, using the resources of the association in a consultant capacity.

Negotiations With MHMS. Having agreed to take no further action pending receipt of the compromise proposal, the Board received this at its July 27 meeting and adopted it at the August 30-31 meeting. The Board appointed an official negotiating team consisting of the president, president-elect, and chairman of the Board of Trustees and empowered the team to seek implementation of the compromise proposal of NABSP.

> The Board of Trustees feels that it is of high importance to note that it sought and accepted the advice of the National Association of Blue Shield Plans, and at no time has the Board arbitrarily exercised the broad authorities granted it by the House of Delegates. It was and is now the belief of the Board that the NABSP compromise proposal has merit and ought to be completely implemented.

The association's negotiating team met with representatives of the Mississippi Hospital and Medical Service on two occasions, October 26 and November 30, 1967. At the first meeting, our representatives were told that the plan's representatives were without power to negotiate. At the second meeting, we were told that the plan could not view with favor points one and two, separate corporations and separate boards of directors, which are the heart and substance of the proposal, but that the other four points could be viewed with favor.

In December, the Board, meeting again, requested information from the plan as to progress in upgrading contracts and the extent of upgrading. The reply, considered at a meeting in February did not, in the opinion of the Board, demonstrate sufficient progress. The Board again asked for conference with the NABSP representatives who responded by meeting at Jackson a second time.

> The president, chairman of the board, and director of professional relations of NABSP reviewed the events of negotiation and communication, expressing the belief that the association should "hold out its hand once more" to the plan, and this advice was accepted.

Response of MHMS. On March 27, 1968, the plan's board of directors adopted a resolution formally declining the NABSP compromise proposal for separate Blue Cross and Blue Shield corporations and so informed the association. Having no further alternatives to explore within the framework of our policies and objectives, the Board of Trustees acted to withdraw association approval of the Mississippi Hospital and Medical Service, Inc., as a Blue Shield plan and to cease furnishing physician-director representation on the plan's board. As requested, the Board informed NABSP, the plan, and the physician-directors of its action.

> The Board did *not* make the decision to apply for a charter and use of the Blue Shield emblem in an effort to establish a new Blue Shield plan in Mississippi. The Board continues to believe that implementation of the NABSP compromise proposal is desirable. The Board now stands and will stand ready to work with the plan in serious effort to implement fully the six-point proposal.

The National Association of Blue Shield Plans has advised the association that its board of directors, in compliance with NABSP by-laws, voted "that the membership of the Mississippi Hospital and Medical Service be placed on a conditional basis pending an investigation by the NABSP Board of Directors."

The Board of Trustees believes that the investigation should proceed in accordance with the NABSP by-laws and that other than to cooperate sincerely in any serious endeavor to implement the compromise proposal for a better Blue Shield plan, no further action should be taken at this time.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Following the 99th Annual Session in 1967, our Board of Trustees has addressed itself seriously and frequently to the issue of Blue Shield in Mississippi. The Board reports a succession of events during 1967-68 under which the advice and counsel of the National Association of Blue Shield Plans was requested in the matter of Blue Shield in Mississippi. NABSP advanced a six-point compromise proposal which includes making a definitive separation of Blue Cross and Blue Shield in Mississippi by having separate corporations for each, establishing separate boards of directors for Blue Cross and Blue Shield with the State Medical Association participating in the election of Blue Shield directors, complete separation of Blue Cross and Blue Shield funds which means two separate treasuries with each plan self-sustaining, issuing separate Blue Cross and Blue Shield contracts or a single contract with Blue Cross and Blue Shield dues (premiums) separately and distinctly identified, a proposal to have the present capable management continue to operate both plans reporting to the two separate boards of directors, and development of Blue Shield benefits on a usual and customary fee basis with the close cooperation of the state medical association, using the resources of the association in a consultant capacity.

Through a series of negotiations, the plan declined to accept points one and two, those of separate corporations and separate boards of directors which the Board of Trustees has stated is the heart and substance of the proposal. The Board has pointed out that it sought and accepted the advice of the National Association of Blue Shield Plans and at no time did the Board arbitrarily exercise the broad authorities reposed in it by the House of Delegates at the 99th Annual Session. The Board has emphasized that it was and is now the belief of the Board of Trustees that the NABSP compromise proposal has merit and ought to be completely implemented.

When the Plan on March 27, 1968, acted formally to decline the NABSP compromise proposal, the Board of Trustees, having no further alternatives to explore within the framework of the policies and objectives given it, acted to withdraw the association's approval of the Mississippi Hospital and Medical Service as a Blue Shield plan in Mississippi. The Board also voted to furnish no further physician-director representation on the plan's board of directors.

The Board did *not* make the decision to apply for charter and use of the Blue Shield emblem in Mississippi or to establish a new Blue Shield plan.

The Board states that it will stand ready and is willing to work with the plan in any serious effort to implement fully the six-point proposal of the National Association of Blue Shield Plans.

Your Reference Committee endorses the action of the Board of Trustees and fully supports its decisions with reference to Blue Shield in Mississippi. Your Reference Committee further concurs in the Board's proposal and belief that the investigation of the plan by the NABSP Board of Directors should proceed and other than to cooperate in serious effort to implement fully the compromise proposal, no further action should be taken at this time.

The report of the reference committee was adopted, and a single "nay" vote was recorded. Dr. S. S. Kety of Picayune, delegate from the Pearl River County Medical Society, voted "nay" on instructions of his society.

SUPPLEMENTAL REPORT "E" OF THE BOARD OF TRUSTEES

HEW Project for the Mississippi Delta: Proposal from HEW. In July 1967, Dr. Francis Land of Washington, director of the Title XIX program for the Department of Health, Education, and Welfare, visited the association and proposed a grant program for a then-undefined area of the Mississippi Delta under which health care would be rendered, public health services would be intensified, and ancillary medical personnel would be trained. A special meeting of the Board of Trustees was conducted on July 27, and Dr. George Silver, the Deputy Assistant Secretary of HEW was present.

> The project was parallel to the "hungry children" hearings conducted by the Clark committee of the U. S. Senate before which witnesses for our association appeared in response to requests from then-Governor Johnson and the two Senators. Senator Stennis introduced legislation for the relief of these conditions where they are demonstrated to exist, and the bill was passed in the Senate and killed in the House. While the legislation was pending, the association ceased conferences with HEW representatives.

In the state, the discussions were expanded to include the University Medical Center, the State Board of Health, and the Mississippi Medical and Surgical Association. Altogether, there were about 12 meetings, and the Board of Trustees has considered 16 reports and related documents on the proposal.

Project Organization. Initially, the president of the association and the chairman of the Board of Trustees acted as the association's official representatives, having been so designated by the Board. Meetings conducted during 1967 were concerned almost exclusively with project organization, and estimates for a health care program ranged from $2 to $30 million per year covering five to 15 counties. A final figure of about $2 million was proposed, and it was tentatively decided that a fourth would be dedicated to the training of ancillary personnel, a fourth would support intensified public health services, and about half would be expended for a limited medical care program in outpatient services.

> The Board of Trustees, recognizing that the project would materialize, took the position that it would restrict our choices much more to be outside the discussion groups and proposed organization than to have representation under somewhat restricted circumstances.

When the Stennis bill was killed in the House of Representatives, discussions were resumed, and a nine-member coordinating council for the Delta project was organized with the Dean and Director of the University Medical Center as chairman. It was agreed that a staff would be employed, and it was further agreed that a public health officer would be furnished from the Atlanta Regional Office of the U. S. Public Health Service to serve as temporary director. The project has been coordinated with the office of the Governor, and the Delta Medical Society has considered it in regular meeting and offered suggestions as to the type of services which can best serve needy individuals in the area.

Association Consideration. As this project develops, the Board continues to monitor it carefully, and Dr. Temple Ainsworth, our President, serves on the committee as our official representative. It is his view and the view of the Board of Trustees that the association must eventually consider the operational program of the project, the policies under which it is managed, the scope and extent of care and the circumstances under which it is rendered, and the actual role which the association will fulfill as relates to the program.

> Obviously, the Board of Trustees and the House of Delegates cannot arrive at a policy decision on a project not yet fully developed. It, therefore, appears appropriate to continue our representation on the project committee, to exert a maximum effort through this representation to shape the program in accordance

with the association's wishes, and to monitor carefully program development.

It is the further view of the President and the Board of Trustees that this course of action neither casts the association in an obstructionist role nor does it commit the association to support of a program yet to be devised. The Board of Trustees recommends approval of this position by the House of Delegates.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

The Board has reported on a proposal from the Department of Health, Education and Welfare to organize under a grant program a program of service to the Mississippi Delta under which limited health care services will be rendered, public health services would be intensified, and ancillary medical personnel would be trained.

During the year, the association has been represented in the organization of this project by the President of our association, Dr. Temple Ainsworth. The program is still in its formative stages and as the Board of Trustees has stated, this House of Delegates cannot arrive at a policy decision on a project not yet fully developed. Your Reference Committee shares the view of the Board that the association must eventually consider the operational program of this project, the policies under which it is managed, the scope and extent of care and the circumstances under which care will be rendered, and the actual role which the association will fulfill as relates to this program.

By continuing our representation on the nine-member committee for the Delta-HEW Project your association has not been committed to the support of a program yet to be devised and we are not cast in an obstructionist role. Your Reference Committee concurs with this position of the Board of Trustees and requests that representation be continued within the framework of policy as reported by the Board.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "F" OF THE BOARD OF TRUSTEES

Title XIX of Public Law 89-97: Prior Actions. At the 99th Annual Session in 1967, the House of Delegates made an extensive review of association policy relating to its position of support for a Title XIX program in Mississippi. Reports were received on the series of information meetings sponsored by the Board in association districts throughout the state. The House of Delegates approved a six-point positive policy on Title XIX recommended by the Board:

(1) Title XIX offers the most desirable course of action in providing health services for needy citizens in the light of alternatives which are virtually assured in its absence. Because it is largely local in nature, it merits support.

(2) Any implementation of Title XIX in Mississippi should, in the interest of patients and their receiving care in their home communities, assure free choice of physician, hospital, and nursing home.

(3) The State of Mississippi must initiate immediately a thorough and comprehensive re-appraisal of all of its health care programs with goals of improving both the quality and quantity of care, of eliminating duplication, and of eliminating inequities upon potential recipients, areas of the state, taxpayers, and providers of care.

(4) The association offers its resources in advising and assisting the state in Title XIX implementation toward the end of faithfully supporting all worthy and lawful effort to establish such a program.

(5) The fiscal administrator for Title XIX in Mississippi must be a competent private or public organization which commands the trust and respect of physicians, hospitals, and all involved in furnishing services.

(6) Implicit in the implementation of Title XIX is the discontinuation of any existing state health and medical program which is conducted only with state funds and/or which would include any individual eligible for services under Title XIX.

In approving the six-point positive policy, the House of Delegates authorized the Board of Trustees to seek implementation of the program in a way which is thoroughly consistent with the recommendations of the Board, including the policy itself.

Interim Actions. The Board of Trustees reviewed the entire succession of events with reference to Title XIX on two occasions during the summer of 1967 as the regional information meeting series was concluded. Copies of the general information brochure used in the meetings and a second brochure containing the six-point positive policy were mailed to every candidate for the legislature in the 1967 elections and to every member of the association. Conferences were conducted by association representatives with appropriate agencies of state government.

1968 Regular Session. Early in the 1968 Regular Session of the Legislature, House Bill 400, a proposed enabling act for Title XIX, was introduced. It was a welfare-oriented proposal and

did not meet association policy criteria for a Title XIX program. The association opposed the measure which has been postponed in committee and is not now being considered.

> The 10 members of the Senate Public Health Committee jointly sponsored Senate Concurrent Resolution 129 which called for appointment by the Governor of a commission of not less than seven members for the purpose of reviewing all health programs and suggesting a Title XIX program and a comprehensive health planning program for the state. The resolution specified that six of the seven members should represent the Mississippi State Medical Association, the State Board of Health, the University Medical Center, the Mississippi Hospital Association, the state mental institutions, and the Legislature. The association supported the measure which was enacted and signed by the Governor.

Governor Williams, as was his prerogative, expanded the commission to include the Mississippi Dental Association, the Department of Public Welfare, and his own office represented by the newly-appointed Coordinator for Federal-State Relations. Four members of each house of the Legislature, including the chairman of health and appropriations committees, serve on the commission. The Governor appointed Dr. Temple Ainsworth of Jackson, our President, as the association's member.

Impression of the Board of Trustees. On April 29, 1968, the commission conducted its initial meeting. From reports, the Board of Trustees has received the impression that action on implementation and funding of a Title XIX program should not be expected during the 1968 Regular Session of the Legislature. No action has been initiated to designate the single state agency responsible for direction of any such program. Rather, the commission has called for studies, particularly as regard scope of services and costs. The Board believes that a special session of the Legislature may be called in 1969 for the purpose of considering a Title XIX program for Mississippi. The Board, pursuant to actions of the House of Delegates in 1967, will continue to pursue enactment and implementation of a Title XIX program consistent with specific association policy.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your Reference Committee considered the supplemental report on Title XIX and we note that the Board has stated that enactment of a Title XIX program during the 1968 Regular Session of the Mississippi Legislature should not be anticipated. We invite the attention of the House of Delegates to the 1967 amendments to Title XIX of Public Law 89-97 and to AMA policy on direct billing of Title XIX patients. We recommend adoption of this policy by the association and we ask that the Board continue in its effort to secure the implementation of a Title XIX program in Mississippi consistent with association policy.

The report of the reference committee was adopted.

REPORT OF THE SECRETARY-TREASURER

Dr. Walter H. Simmons: Duties and Responsibilities. As an elected general officer of your association, your Secretary-Treasurer is charged with such duties as ordinarily devolve upon the secretary of a corporation by law, custom, and usage. Additionally, he is the constitutional designee as chairman of the Council on Scientific Assembly and a member *ex officio* of all councils and committees.

Membership. There was little change in membership totals for 1967 as compared with 1966. The 1967 total includes:

1,245 paid Active members
80 Emeritus members
48 members exempt from dues other than Emeritus

This is a total for 1967 of 1,373 members on the rolls of your association. The trend for 1968 suggests that the association will enjoy a modest growth this year, and the current membership program is progressing most satisfactorily. On May 1, 1968, there were 1,331 members in good standing on the rolls, as compared with 1,326 a year previously. It is notable, however, that there are almost 50 more paid Active members as of May 1, 1968, then on the same date in 1967. Some component societies have not certified their Emeritus members for 1968 as of May 1. Had they done so, the 1968 total would closely approximate that of the full year 1967. Totals for 1968 as of May 1 are:

1,244 paid Active members
52 Emeritus members
35 members exempt from dues other than Emeritus

The association commends the following component societies for having secured 100 per cent of their renewable 1967 membership as of May 1, 1968:

Amite-Wilkinson County Medical Society
Claiborne County Medical Society
North Central District Medical Society
Pearl River County Medical Society
West Mississippi Medical Society

Fiscal Reporting. In accordance with usual practice, your Secretary-Treasurer submits a condensed statement of your association's fiscal condition as of April 30, 1968, as an attachment to this report. The Council on Budget and Finance has reviewed the fiscal records, considered a budget for 1968-69, and has reported to the Board of Trustees in this connection. An overall budget of $171,580.00 has been recommended and approved by the Board, and a copy of the budget is attached to this report. This amount is exclusive of funds which the association will expend in payment of professional fees under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) which will be reimbursed to the association by the Department of Defense. For this purpose, we hold a capitalization, interest-free, of $99,000.00, an increase of $34,000.00 over last year.

MISSISSIPPI STATE MEDICAL ASSOCIATION
CONDENSED STATEMENT OF
FINANCIAL CONDITION
APRIL 30, 1968

ASSETS

Current Assets		
General Fund		
Cash on deposit	$116,549.01	
Due from Department of Defense, CHAMPUS administrative costs	3,178.97	
Due from advertisers	6,718.93	
Other receivables	368.15	
Prepaid expenses	1,179.97	$127,995.03
CHAMPUS		
Cash on deposit, professional fee account	39,412.21	
Due from Department of Defense, professional fee account	59,587.79	99,000.00
Fixed Assets		
Building and equipment, less depreciation	69,800.54	
Land	13,605.30	83,405.84
Total book assets		$310,400.87

LIABILITIES AND NET WORTH

Current Liabilities		
Amortization, building, current year	$ 5,335.59	
1968 AMA dues in process	3,010.00	
CHAMPUS capitalization	99,000.00	$107,345.59
Long Term Liabilities		
Building	13,865.21	13,865.21
Net Worth		
Unappropriated net worth	189,190.07	189,190.07
Total liabilities and net worth		$310,400.87

Constitutional Duties. Your Secretary-Treasurer, as an *ex officio* member of all councils and committees, meets with various official bodies of the association and sits with the Board of Trustees as a general officer. Activities in connection with service as chairman of the Council on Scientific Assembly have been reported separately.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

We thank the Secretary-Treasurer, Dr. Walter H. Simmons of Jackson, for his report and we have received with great satisfaction the information that our membership may enjoy a modest increase during the 1968-69 association year. We approve the report of the Secretary-Treasurer and recommend its adoption by the House of Delegates.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON BUDGET AND FINANCE

We have considered the fiscal portion of the report of the Secretary-Treasurer and we have examined the operation of the association with respect to all fiscal activities, including the report of the independent certified public accountant. The findings are to the satisfaction of your council. Prior to this annual session, and during the annual session, we met for these purposes and have conferred with the Board of Trustees. We have determined that all accounts, receipts, and disbursements are regular and authorized.

Association Budget. We have considered the 1968-69 budget for operation of your association. We have conferred with the Board of Trustees who concur in our recommendations. Each item has been carefully evaluated as to necessity and adequacy. We recommend a total budget of $171,580.00 which includes the following sums for purposes stated: (1) for general operation of all activities and departments of the association, including production of your JOURNAL, $122,866.74; (2) for building amortization, utilities, maintenance, taxes, and associated expenditures, $13,009.72. This amount also includes $12,500.00 for the conduct of the present annual session and the remainder for reserves and contingent funds. The overall budget total is exclusive of professional fee aspects of the CHAMPUS program which is reimbursed to the association by the Department of Defense. We recommend adoption of this amount as being a realistic minimum for continued effective operation of your association.

Your council points out that for each member paying state dues of $60 per year, we will spend

$124 for association services to him in this budget. We will put aside $4 for future services and we will hold more than $9 for unforeseen needs to serve him further in 1968-69. This is a total of more than $137 per dues paying member.

Insurance and Safeguards. We have examined a survey of insurance owned by the association on its physical properties and we find it adequate. Suitable safeguards for disbursements procedures, fidelity bonds, and proper safekeeping for records have been provided.

The report of the council was adopted.

REPORT OF THE EXECUTIVE SECRETARY

Mr. Rowland B. Kennedy: Duties and Responsibilities. Your Executive Secretary is responsible for maintaining the headquarters office, for conducting the administrative affairs of the association, and for various fiduciary duties as required by Article VII of the Constitution and Section 7, Chapter VII, of the By-Laws. Because your Executive Secretary reports frequently and in detail to the Board of Trustees and general officers, this report is purposely brief and limited in scope.

Executive Staff: Since the 99th Annual Session, the regular workload of the executive staff has virtually doubled. Two factors account for this increase: The expansion of the CHAMPUS program and the additional work of the association, principally under the Board of Trustees. Four staff members have been added during the 1967-68 association year, all for the CHAMPUS department. The Board of Trustees and general officers are conversant with staffing needs and work volume which are closely and continually coordinated with them. It is especially gratifying that your association has been successful in recruiting and training staff members possessing excellent qualifications and specialized skills.

In addition to routine duties in membership, accounting, JOURNAL production, medical care plan administration, and staff assistance to the Board, officers, councils, and committees, your executive staff is regularly performing studies, surveys, socio-economic research, and supportive services relating to programs of the association.

Expression of the Staff. The staff is grateful for the opportunity of serving and in sharing some small part in the successes of the association. We deeply appreciate the *rapport* with all association officials and component medical societies, and we pledge our continued best effort in your behalf.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your Reference Committee has considered the report of the Executive Secretary in which he has outlined the functions and duties of our executive staff. We express appreciation to the staff for their services. We approve the report of the Executive Secretary and recommend that it be adopted.

The report of the reference committee was adopted.

REPORT OF THE DELEGATES TO AMA

Reporting Format. Because of excellent reporting of AMA annual and clinical conventions through the *Journal AMA* and the *AMA News,* your Delegates to the American Medical Association have limited this report for the calendar year 1967 to a review of policy actions. The report is concerned with the Atlantic City annual and Houston clinical conventions. There were no special or called meeting of the House of Delegates in 1967.

Atlantic City Annual Convention. Your regularly elected Delegates, Drs. J. P. Culpepper, Jr., of Hattiesburg and Howard A. Nelson of Greenwood, were seated at the Atlantic City meeting, the 116th Annual Convention, June 18-22, 1967. Principal issues before the House of Delegates included therapeutic abortion, health care costs, government financing of health care, physician control over professional fees, postgraduate medical education, and the relationship of medicine and osteopathy. A record volume of business was considered by the House, a total of 151 items, including 123 resolutions from state medical associations, 18 reports of the Board of Trustees, four reports of the Council on Medical Service, and six reports from other councils. There was 100 per cent attendance by the 242 members of the House.

For the first time since 1871, AMA policy on therapeutic abortion was substantially revised with a view toward introducing adequate safeguards to prevent abuse and to recognize scientific advances and ethical aspects. The policy permits the physician to exercise the dictates of personal conscience and medical judgment in the best interests of his patient. The policy expresses opposition to induced abortion except when (1) documented medical evidence indicates that continuation of the pregnancy may threaten the life or health of the mother, or (2) there is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency. or (3) there is documented medical evidence that continuance of the pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient; (4) two other physicians chosen because of their recognized professional competence have examined the patient

and have concurred in writing, and (5) the procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

The policy also states that it is ethical for physicians to provide medical information to state legislatures in consideration of legislation revising or developing laws on therapeutic abortion.

The House of Delegates recognized that the ability of the physician to serve his patient is being handicapped by rapidly rising costs of the various components of health care, and the House also stated that the problem of medical indigency will assume alarming proportions. The House frankly questioned the present organization and management of the nation's hospitals with respect to their "privilege of automatically translating all higher costs into higher prices."

The Delegates called for strengthening of voluntary insurance plans to provide better benefits, and a commitment was made to suggest guiding principles for health insurance and prepayment programs.

A large number of reports and resolutions dealt with the growing role of government in health care financing. The House reaffirmed the principle that no one should go without needed care because of inability to purchase it but also said again that responsibility first rests with the individual himself and then, to the extent that he is unable to pay, to the family, community, county, state, in that order, and only then to the federal government.

The House firmly and decisively gave support to Title XIX as the means for improving health care and the delivery of services to the needy of the nation. The policy called for organized medicine to take a leading role in "formulating and directing Title XIX programs at state level."

In codifying policies on physician control over the collection and disbursement of professional fees, the House stated that it is proper for a physician to establish the fee he charges with "the recognition that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge." The House agreed that it is proper for a third party to make payment of professional medical fees for patients. The principles of the Hess Report of 1949 and 1961 were reaffirmed in the disposition of professional services.

The Report of the Citizens Commission on Graduate Medical Education, popularly known as the Millis Report, was thoroughly discussed, but it has not as yet been formally placed before the House of Delegates.

Authorization was given to the Board of Trustees to begin negotiations to convert schools of osteopathy into schools of medicine, recognizing that funds of the AMA may be needed for this purpose. Medical manpower problems were reviewed, and a settlement of the problem over the disability insurance program was achieved. The program was continued with another carrier with guaranteed benefits and premium levels for five years. Several resolutions were adopted reaffirming the policy that a physician should be free to prescribe for his patient by brand or generic designation.

Your Mississippi Delegates introduced Resolution No. 72, subject: AMA Aims, based on actions taken at the 99th Annual Session in adopting Resolution No. 3, same subject, introduced by the Delta Medical Society. The resolution was referred to the Board of Trustees for action.

Houston Clinical Convention. The 21st Clinical Convention of AMA was conducted at Houston, Texas, November 26-29, 1967, and your association was represented by Dr. Howard A. Nelson of Greenwood and Dr. B. B. O'Mara of Biloxi, Dr. Culpepper being unable to attend. Two hundred thirty-eight of the 242 Delegates were seated and considered 96 items of business. Both Dr. Nelson and Dr. O'Mara served as members of reference committees of the House.

Health care and services, Medicare and Title XIX, health manpower, education, and Blue Shield were major items for action by the House.

The House took a vigorous stand supporting care standards that are purely local in development and nature, opposing the disturbing trends toward possible establishment of medical care standards on a national basis. Another action committed the AMA, the profession, and state associations to informing the public as to practical means of moderating rising health care costs, the value of voluntary health insurance, and the expansion of medical manpower. Encouragement for involvement of the profession in comprehensive health planning and a critical examination of professional liability implications in utilization of allied professional personnel were sought.

The House again supported direct billing under Part 1-B of Title XVIII, and asked that AMA continue efforts for implementation of Title XIX in such a way as to recognize "the physician's right to bill directly all patients, including Title XIX patients," and which "allows the physician or his patient to be reimbursed his usual, customary, and reasonable fee for his professional services."

Resolutions were adopted urging membership of physicians on hospital governing boards as the

best means for effective liaison between medical staffs and governing authorities, for protecting hospital privileges through "due process," calling for better liaison between hospital staffs and local medical societies, for simplifying attendance requirements for staff meetings, and for pressing for prompt revision of JCAH rules on use of externs in non-university-affiliated hospitals.

In a special report, the Board of Trustees presented a new 11-point positive statement on the aims of AMA, an outgrowth of Resolution No. 72, introduced by your Delegates. This new statement of purposes and responsibilities greatly enlarges AMA aims and takes into account the goals and objectives contained in the Mississippi position.

The House approved in principle relocation of the AMA-ERF Institute for Biomedical Research from the Chicago headquarters building to the University of Chicago campus. Under a new procedure, the House voted to present the 1968 AMA Distinguished Service Award to Dr. Owen H. Wangensteen at the San Francisco annual convention. A number of revisions of the By-Laws were adopted, and these related to organization of the AMA.

In three actions on Blue Shield, the House voted to request the Council on Medical Service to develop guiding principles for improvement of programs, second, to make a determination of the proper objective of voluntary health coverage, and third, calling "upon medical society officers and executives to participate in the activities of their respectively sponsored or approved plans so that all such plans shall, in fact, be and continue to serve as economic arms of the medical profession in offering sound alternatives to the public in the voluntary financing of health care."

Retirement of Delegate. Your incumbent senior AMA Delegate, Dr. Nelson, reports that after serving eight consecutive terms, 16 years, during which he also served as an AMA committee chairman, Vice President, and a member of the Board of Trustees, Dr. J. P. Culpepper, Jr., of Hattiesburg retired as Delegate to AMA from Mississippi. On January 1, 1968, Dr. G. Swink Hicks of Natchez began service as a Delegate, and he will be seated at the San Francisco annual convention.

Expression of Delegates. Your AMA Delegates express appreciation to the state medical association's Board of Trustees and general officers for guidance and support and for the continuing communication among us which enables us to represent the policies and wishes of our association in the AMA House of Delegates.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your Reference Committee expresses appreciation to the Delegates to the American Medical Association and we take this opportunity to commend Dr. J. P. Culpepper, Jr. of Hattiesburg who retired as our senior delegate at the end of 1967. During his 16 years of service as a delegate from Mississippi State Medical Association, Dr. Culpepper has held AMA committee chairmanships, has been Vice President of the AMA, and a member of the AMA Board of Trustees.

Your Reference Committee takes this opportunity to wish Dr. G. Swink Hicks of Natchez a successful tenure of service as a delegate to AMA when he begins service with Dr. Nelson. We approve the report of the AMA delegates and recommend its adoption.

The chairman of the reference committee moved adoption of the report, and Dr. C. D. Taylor, Jr., secretary of the Board of Trustees, moved to amend the report by asking that the House of Delegates commend Dr. Culpepper on his outstanding service, seconds by Dr. John B. Howell, Jr., chairman of the Board, and Dr. Lamar Arrington, vice chairman of the Board. The chair put the motion which was unanimously adopted as amended, and the House of Delegates accorded Dr. Culpepper a standing ovation.

ANNOUNCEMENT OF THE NOMINATING COMMITTEE

Following a recess for caucuses by association districts, the Nominating Committee was announced:

E. LeRoy Wilkins, Clarksdale, District 1.
James O. Gilmore, Oxford, District 2.
Thomas W. Wesson, Tupelo, District 3.
S. Lamar Bailey, Kosciusko, District 4.
J. A. K. Birchett, Vicksburg, District 5.
Charles B. Mitchell, Jr., Meridian, District 6.
C. R. Jenkins, Laurel, District 7.
W. M. Dabney, Crystal Springs, District 8.
B. B. O'Mara, Biloxi, District 9.

Dr. O'Mara was elected chairman by the committee which conducted open sessions on May 15, 1968, and posted the nominations at the headquarters hotel on that date.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties. The Council on Scientific Assembly is a constitutional body of the House of Delegates. It is charged with the responsibility of planning the annual sessions of the association to include all scientific activity and the programming and scheduling of annual session events. The council membership consists of the

chairmen and secretaries of the several scientific sections and the secretary-treasurer of the association.

100th Annual Session. This annual session marks the centennial meeting of the association, although the association was founded in 1856. Your council believes that the scientific format planned for this meeting represents a fitting memorial to 100 years of postgraduate medical education in Mississippi and a significant preview of the next 100 years in this vital area of professional interest and endeavor. With the valued support and co-operation of the Medical Television Department of Smith Kline and French Laboratories and the University of Mississippi School of Medicine, your council has scheduled live, color television presentations as a significant portion of the scientific program at this annual meeting. This event has required the time and effort of individuals too numerous to mention in this report. Your council expresses appreciation to all involved and especially to the color television program chairman, Dr. William O. Barnett, and the several television moderators, Drs. George D. Purvis, J. Harvey Johnston, James L. Royals, Robert D. Currier, Herbert G. Langford and James Grant Thompson.

Scientific Film Program. At the 99th Annual Session, your council initiated a program of scientific films to precede each section meeting. These several programs were well received and your council, therefore, continued the scientific film program for this meeting. An effort has again been made to co-ordinate this portion of each section with the live scientific program to follow. Your council acknowledges with appreciation the work of its film program chairman, Dr. Calvin T. Hull.

Ainsworth Resolution. At the 93rd Annual Session, 1961, the House of Delegates implemented a resolution introduced by Dr. Temple Ainsworth calling on the several scientific sections of the association to confer with specialty society representatives from the fields of orthopaedic surgery, neurosurgery, anesthesiology, pathology, radiology and urology towards placing papers before the several sections from these specialties. Following up on this resolution, your council has written the officers of specialty societies in these several medical disciplines prior to each annual session urging requests for program time. On many occasions such requests have been made and essayists have appeared before the scientific sections from these specialties. On several occasions, however, requests for time have been received subsequent to the formalizing of section programs. In this regard, your council would like to take this opportunity to urge early requests for such time even to the extent of contacting the section officers concerned at this annual meeting if program time is desired at the 101st Annual Session to be conducted in 1969.

Financing Annual Meetings. The association sponsored activities of our annual meetings, as with similar medical meetings, are financed entirely by sales of exhibit space except for the annual association party. This is in contrast to association meetings which are financed entirely or in great part by registration fees. Although we have been fortunate in the degree of supportive continuity shown by pharmaceutical companies in our annual meetings, and your council foresees no immediate drastic change in this trend, it should be noted that numerous medical meetings are experiencing a definite problem in this regard. The council wishes the House of Delegates to be aware of this situation and assures you that it will receive our continued observation so that alternatives to present financing mechanisms may be proposed if necessary.

Specialty Society Meetings. Your council is happy to report that sixteen specialty and other medical groups will meet concurrently with this annual session of the association. This combination of meetings benefits all groups involved in competing for the time of the busy physician, and your council urges the support of the House of Delegates in encouraging a fuller implementation of this annual meeting concept.

Scheduling of Annual Sessions. At the 98th Annual Session, this House of Delegates, on recommendation of the council, adopted a three year advance schedule of annual sessions. At the 99th Annual Session this House of Delegates, again on recommendation of the council, agreed to hold all future annual sessions on the Gulf Coast after the 1968 meeting in Jackson. A basic factor in this recommendation was the decline in convention facilities in Jackson compared to the continued improvement of facilities on the Coast.

The matter has become even more acute in Jackson, and your council wishes to note that it has experienced tremendous difficulties in finding adequate meeting space for the various functions conducted during this annual session. There is no indication that this situation will improve in the immediate future and your council, therefore, especially recommends that the House of Delegates continue to pursue its course of holding all future annual meetings on the Gulf Coast.

Expression of the Council. Planning and organization of this annual session began with a meeting of the council on August 2 of last year.

Your council is grateful for the support, assistance, and co-operation it has received from all concerned with this meeting. We trust that the 100th Annual Session will be professionally profitable and personally enjoyable to all.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee does not believe that it can too strongly commend our Council on Scientific Assembly for its excellent organization and conduct of the 100th Annual Session. This annual meeting has been one of the most outstanding ones in the history of our association and we are especially grateful to the Medical Television Department of Smith Kline and French Laboratories and the University of Mississippi School of Medicine for their roles in making this statement possible. Your reference committee also wishes to express appreciation to all the participants on the several television programs presented at this meeting. It is our understanding that each program required several meetings over the past year and we commend the television program chairman, Dr. William O. Barnett, and the several television moderators, Drs. George D. Purvis, J. Harvey Johnston, Jr., James L. Royals, Robert D. Currier, Herbert G. Langford, and James Grant Thompson in making this an outstanding scientific meeting.

Your reference committee wishes to associate itself with the remarks of the Council in recommending "that the House of Delegates continue to pursue its course of holding all future annual meetings on the Gulf Coast." The site for the 1971 meeting of the association should be selected at this meeting in accordance with prior actions of the House of Delegates setting up a three-year schedule of annual meetings.

The report of the reference committee was adopted.

103RD ANNUAL SESSION

Dr. C. D. Taylor, Jr., of Pass Christian moved that the association conduct its 1971 annual session at Biloxi, seconds by Dr. Rhea L. Wyatt of Holly Springs and Dr. B. B. O'Mara of Biloxi. There being no discussion, the chair put the motion which was adopted.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties. The Council on Medical Service is a constitutional body of the House of Delegates. It is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under its jurisdiction there are assigned the activities of the association in medical service, emergency service programs, indigent care and allied medical agencies. The council is assisted in its work by three constitutional committees and three *ad hoc* committees. Programs, studies and activities of the council's several committees during the 1967-68 association year embraced a wide range of subject areas and policy development. These were:

Committee on Maternal and Child Care. This committee has the responsibility of studying every maternal death occurring in the state. Meaningful postgraduate education in maternal and child care is the goal of the committee's activities. During the past year the committee, following the AMA's *Guide for Maternal Death Studies,* reviewed and evaluated 28 maternal deaths occurring in the state. Each attending physician in these cases was confidentially informed of the committee's findings. As of February, 1968, the committee had sent out 533 inquiries on maternal deaths since its study began in January, 1957. Replies have been received in 441 or 82.7 per cent of these cases.

As its major postgraduate education project this year, the committee has developed a set of Maternal and Child Care Desk Cards and distributed them to all hospitals in the state for use in OB care. The cards are concerned with outlining care for the difficult OB situation. They will also be distributed to interested physicians and other groups in the state. Supplementary to its studies, the committee has presented the following scientific paper in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION: "Case Report XIII of Maternal Mortality Study," July, 1967.

The committee has also continued to reduce its study data to IBM and adjunctive to this project, the committee will prepare articles for publication in the JOURNAL MSMA this year which are based upon its maternal mortality IBM data. A scientific exhibit based upon this data is also being considered as a committee project for presentation at society and annual meetings of the association and before other interested groups.

Committee on Occupational Health. This committee has responsibility for studying all aspects of occupational health in Mississippi. Following up on the preparation and presentation of its study and report, "Occupational Health Programs in Small Plants in Mississippi," to the House of Delegates last year, a major paper was prepared on this project and presented by the committee's chairman before the 27th Congress on Occupational Health sponsored by the American Medical Association. The committee's report has been requested and distributed on both the national and state level. The Mississippi Manufacturers' As-

sociation has distributed the report to all its members.

Members of the committee are preparing a series of articles concerning various subjects in the field of occupational health for publication in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION. The first article titled "Workmen's Compensation Forms" appeared in the August, 1967, issue of the JOURNAL. Based upon previous authorities granted by the House of Delegates, the committee will work this year towards preparing a guide for occupational health programs in small plants in Mississippi, and it is anticipated that this project will be the subject of a major report to the House of Delegates at next year's annual meeting.

Committee on Mental Health. This committee has responsibility in the broad field of mental health activities. The problem of drug control and abuse has recently become a subject of serious concern in the state, and the chairman of the committee has met with a group composed of interested authorities in this connection. The chairman of the committee also attended the 14th Annual Conference of State Medical Society Mental Health Representatives sponsored by the AMA in Chicago, March 15-16, 1968. Drug abuse was the primary topic of this important conference.

Committee on Nursing (ad hoc). This committee has responsibility for conducting a program of active liaison with the Mississippi Nurses' Association. During the past year the chairman of the committee attended the AMA's first special conference on nursing in Chicago, October 6, 1967. Three subject areas have been proposed for consideration by the committee and its counterpart from the Mississippi Nurses' Association—i.e., mandatory licensure of nurses; the future role of the hospital diploma school; and programs to reclaim the retired nurse. An early summer meeting will be held in this connection.

Health Insurance Benefits Advisory Committee (ad hoc). This committee was established by the council to act as a fact-finding and advisory committee on professional problems that might arise with respect to the operation of the Medicare Program in Mississippi. Among public and private agencies in Mississippi the committee met with last year was the Medicare Unit of the Mississippi State Board of Health which serves as certifying agency for providers of care in Mississippi under Medicare. This agency desires and requires a professional advisory committee of practicing physicians and has requested that the association's Health Insurance Benefits Advisory Committee serve in this capacity. Your council approves and commends this request. The committee will additionally continue to serve as a fact-finding body on Medicare and your council again urges the membership to contact the committee when problems are encountered in this regard.

Committee on Blood and Blood Banking (ad hoc). This committee has responsibility for monitoring all aspects of blood banking and transfusion service and professional and socio-economic policy in this regard. At the association's 99th Annual Session, the committee reported on establishment of a blood and blood plasma program at the Mississippi Penitentiary at Parchman and was urged by the House of Delegates to closely monitor the program and report on its operation. In this connection, the committee made its first on-site inspection of the finalized program this year. A special report was presented by the committee in the February 1968 issue of the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, and the committee stated in this regard that it "is favorably impressed with the permanent facility which has been constructed (at Parchman), with the personnel, the direction of the program, and with the overall beneficial effect on the situation. . . ."

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee is impressed by the work of the Council on Medical Service and its several committees as outlined in the annual report of the council. Our Council on Medical Service is charged with the responsibility of studying all aspects of medical care in Mississippi and its annual report signifies the content and scope of this charge.

The Council's Committee on Maternal and Child Care continues its important study of maternal mortality in Mississippi. During the past year this committee has developed a set of Maternal and Child Care Desk Cards concerned with outlining care for the difficult OB situation. The cards will be distributed to all hospitals in the state and to interested physicians. The committee continues to reduce to IBM its study data on over 500 maternal deaths occurring in Mississippi since 1957, and this project will be presented in a series of articles scheduled to be published in our JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION. The committee notes a continued decline in the maternal mortality death rate for our state.

The Council's Committee on Occupational Health reports that it will work this year towards preparing a guide for occupational health programs in small plants in Mississippi, thus concluding the outstanding study and report titled

"Occupational Health Programs in Small Plants in Mississippi" presented to this House of Delegates last year. During the past year, members of this committee have developed a series of articles concerning various occupational health subjects for publication in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, and your reference committee commends these articles to your attention.

The Council's several other constitutional and *ad hoc* committees in the fields of mental health, nursing, blood and blood banking, and health insurance continue work in their respective areas of interest and your reference committee notes and commends their endeavors in this regard. The activities of these committees have covered everything from meetings on drug abuse to trips to our Mississippi Penitentiary at Parchman, thankfully, your reference committee notes in the latter regard, as invited visitors.

With the foregoing remarks, we approve the report of the Council on Medical Service and recommend its adoption.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT "A" OF THE COUNCIL ON MEDICAL SERVICE

Policy Recommendations: Your Council on Medical Service has reported on the work of its several committees for the 1967-68 association year in the *Handbook of the House of Delegates* and respectfully commends this report to the attention of each member of this House of Delegates. Based upon its constitutionally assigned duties to ascertain and study all aspects of medical care in Mississippi and to report its findings in this connection to the profession your council has considered a wide range of subject areas and policy development during the 1967-68 association year which are presented for this House of Delegates' attention at this time.

Utilization Review Conferences. Under authorities granted by this House of Delegates the Council on Medical Service organized and conducted a series of utilization review conferences over the state during the past year in co-sponsorship with the Mississippi State Board of Health. The conferences featured a presentation by Dr. Vergel N. Slee, Director of the Commission on Professional and Hospital Activities and a panel discussion conducted by physicians who serve on utilization review committees in the several areas where the conferences were held. The conferences were in general well received and it is your council's hope that future conferences may be conducted as needed and proven beneficial in informing physicians on professional aspects of Public Law 89-97 (Medicare).

Physician Representation on Hospital Governing Boards. At the 99th Annual Session, 1967, the House of Delegates adopted a policy recommendation from the council that "each hospital in the state have at least two voting doctors of medicine on its governing board who are either appointed or elected by the hospital medical staff from its membership." In a letter to all hospital chiefs-of-staff in February of this year your council urged that this policy statement be brought to the attention of the respective hospital medical staff and pointed out that county hospitals, which comprise the largest category of public hospitals in the state, had their Boards of Trustees appointed by the appropriate County Board of Supervisors. Your council now proposes to survey each hospital in the state as to the form of liaison established between its governing board and medical staff and report to the House of Delegates in this connection at the 101st Annual Session, 1969.

Emergency Medical Care Services. The American Medical Association, American College of Surgeons and U. S. Public Health Service have recently concluded studies of community emergency health care services in the United States and jointly noted the need for an immediate upgrading of such services. In our own state we have witnessed an increased public interest in emergency medical care services and oftentimes unfortunate misunderstanding of what the scope and context of meaningful community emergency care services can and should be. Community emergency medical care services will be a prime area of concern for your council during the next few months.

Commitment and Treatment of Alcoholics. Your council has continued its study of commitment and treatment procedures in Mississippi for alcoholics as endorsed by the House of Delegates at the 99th Annual Session. During the past year there has been increased public interest in this subject as witnessed by the specific inclusion of monies in the Mental Health Program for treatment of alcoholics and the introduction of legislation in the Mississippi Legislature which would apply present commitment procedures for alcoholics to facilities participating in the Mississippi Mental Health Program.

Policy on Therapeutic Abortion. Within the past few years there has been an increased public and professional interest in state abortion statutes especially as they pertain to provisions for therapeutic abortion. At the June, 1967, meeting of the American Medical Association, a detailed

document on therapeutic abortion was presented by the AMA Committee on Human Reproduction which as adopted by the AMA House of Delegates in essence stated that the American Medical Association is opposed to induced abortion except when:

"(1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or

(2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

(3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient;

(4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and

(5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

It is to be considered consistent with the principles of ethics of the American Medical Association for physicians to provide medical information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion."

Your council wishes to bring the above policy statement to the attention of the House of Delegates especially in the light of present statutes in Mississippi which recognize two situations for performance of an abortion by a physician, i.e., "where necessary for the preservation of the mother's life" and "where pregnancy was caused by rape."

Officers of the Council. During the 1967-68 association year, the following served as officers of the council: Guy T. Vise, Meridian, Chairman, and John G. Caden, Jackson, Vice Chairman. Other members of the council are: George F. Archer, Greenville; James O. Gilmore, Oxford; Jack M. Senter, Belmont; Paul B. Brumby, Lexington; Charles R. Jenkins, Laurel; Jack A. Atkinson, Brookhaven; and Bedford F. Floyd, Jr., Gulfport.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee has considered the policy recommendations of the Council on Medical Service and recommends the following in this regard:

(a) *Utilization Review Conferences.* We commend the Council on its organizing and presenting a series of utilization review conferences during the past year and note that future conferences may be conducted as needed and proven beneficial in informing physicians on professional aspects of Public Law 89-97 (Medicare).

(b) *Physician Representation on Hospital Governing Boards.* The Council reports on a mailing to all hospital chiefs-of-staff in the state informing them of the association's policy recommendation concerning physician representation on hospital governing boards and proposes to survey each hospital in the state as to the form of liaison established between its governing board and medical staff as a followup to this mailing. During discussion before your reference committee concerning this subject, the varied mechanisms and importance of liaison between hospital governing boards and their medical staffs were clearly outlined as physicians from different areas of the state described their experience in this regard. Your reference committee believes that the study proposed by the Council would accomplish the twofold result of keeping this timely subject before all physicians in the state and furnishing the association valuable data upon which to base its future actions regarding this subject. It, therefore, recommends that the study be undertaken.

(c) *Emergency Medical Care Services.* Your reference committee gave extended attention to a review and discussion of the timely subject of emergency medical care services. We believe that it cannot be stressed too strongly to physicians in Mississippi that this area of professional concern will come more and more under public scrutiny. We must each ask ourselves—"How are emergency care services organized in my community and how well are they meeting the needs of my community in this regard?" We commend the council for its plan for an extended program in this subject area.

(d) *Commitment and Treatment of Alcoholics.* The council reports that it continues its studies of commitment and treatment procedures for alcoholics and your reference committee commends the council's activities in this regard.

(e) *Policy on Therapeutic Abortion.* The council has presented a recent policy statement on therapeutic abortion developed by the AMA Committee on Therapeutic Abortion and adopted by the AMA House of Delegates at its June, 1967 meeting. In this regard it is noted that there are at present two situations recognized in Mississippi statutes for performance of an abortion by a physician, i.e., "when necessary for the preservation of the mother's life" and "where pregnancy was

caused by rape." Your reference committee recommends that the AMA policy statement on therapeutic abortion be directed to the attention of our Council on Legislation for guidance purposes in reviewing proposed changes in the Mississippi abortion statute.

The report of the reference committee was adopted.

REPORT OF THE COMMITTEE ON AMA-ERF

Organization and Duties. Your Committee on AMA-ERF is composed of one member from each component medical society appointed annually by the president of our association. The committee works in conjunction with the American Medical Association—Education and Research Foundation and solicits voluntary contributions from Mississippi physicians for medical education and research. All contributions are tax deductible and every dollar received is put to work in education in a medical school of the donor's choice or in medical research.

1967 Contributions. Your committee is happy to report that Mississippi physicians contributed $10,194.68 to AMA-ERF during 1967. This is the largest annual amount ever received and represents a 30 per cent increase over 1966 contributions. Our University of Mississippi School of Medicine's AMA-ERF allocation for 1967 is $11,473.16. Over 80 per cent of this amount represents contributions from Mississippi physicians; the remainder is the University's share of undesignated contributions.

1968 Program. Your committee earnestly solicits a contribution to AMA-ERF from every Mississippi physician in 1968. We commend to you in this regard the policy of a number of the association's component medical societies to devote a portion of one society meeting each year to an appeal for AMA-ERF contributions.

Presentation of UMC Contribution. At this time I ask the Dean of our University of Mississippi School of Medicine to come forward and accept on behalf of the medical school its 1967 AMA-ERF contribution, a check in the amount of $11,473.16.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee is pleased to note that Mississippi physicians and Auxiliary members gave over $10,000.00 last year for support of our medical schools through AMA-ERF. We urge continued support for this worthy program. We approve this report and recommend its adoption.

The report of the reference committee was adopted.

SPECIAL AMA-ERF PRESENTATION

The Speaker invited Dr. Robert E. Carter of Jackson, dean and director of the University Medical Center, to the rostrum. The President, Dr. Ainsworth, presented Dr. Carter with a check for $11,473.16 as a unrestricted gift to UMC of which Mississippi physicians and Auxiliary members had contributed $10,194.68. Dr. Carter, in accepting the gift for the University Medical Center, expressed his appreciation and that of the medical school.

RESOLUTION NO. 1, IN MEMORIAM

Dr. Walter H. Simmons: WHEREAS, There are absent from among our numbers 27 members who have been called by Divine Providence since the 99th Annual Session; and

WHEREAS, Although we are grieved upon the passing of these beloved colleagues and friends, we are inspired by their lives of service and professional attainment; and

WHEREAS, This expression of our grief, deep affection, and respect should be recorded permanently among official records of the Mississippi State Medical Association, now, therefore, be it

Resolved, That this House of Delegates does mourn the passing of the following esteemed colleagues:

Richard B. Austin, Forest, October 8, 1967
James M. Beeler, Meridian, August 6, 1967
R. B. Caldwell, Baldwyn, May 7, 1968
Edwin F. Chanton, Biloxi, May 8, 1967
M. Q. Ewing, Amory, August 8, 1967
Thomas M. Gore, Houston, September 30, 1967
Archie L. Gray, Jackson, March 4, 1968
William T. Harper, Fayette, August 12, 1967
Frank B. Hays, Columbus, January 1, 1968
Nathan F. Kendall, Mendenhall, April 11, 1968
William D. Love, IV, Jackson, May 22, 1967
Robert C. Massengill, Brookhaven, November 4. 1967
William R. May, Brookhaven, November 13. 1967
James N. Mecklin, Louise, November 21, 1967
Stova B. McIlwain, Pascagoula, June 6, 1967
Sterling S. McNair, Jackson, January 5, 1968
Lancelot L. Minor, DeSoto County, March 2, 1968
David M. Pennebaker, New Albany, July 18, 1967
William E. Richards, Artesia, December 31, 1967
Woodson A. Stevens, Biloxi, March 14, 1968
Robert L. Suber, Pascagoula, November 7, 1967
Hal Mabry Terry, Goodman, July 4, 1967
Irvin B. Trapp, Port Gibson, June 20, 1967
Marcus E. Waring, Tylertown, May 16, 1967
Perry R. Wasson, Lyon, February 27, 1968
William H. Weeks, Yazoo City, March 20, 1968
Richard N. Whitfield, Florence, June 30, 1967

ACTION OF THE HOUSE OF DELEGATES

Without objection, Resolution No. 1 was acted upon without referral and adopted by the House of Delegates with all present standing in silent tribute.

RESOLUTION NO. 2, OFFICE OF COUNTY CORONER

Dr. Leo J. Scanlon: WHEREAS, The Mississippi State Medical Association is dedicated to the service of the people of Mississippi, and

WHEREAS, The Office of County Coroner renders service to the public, and

WHEREAS, The coroner must make vital medical decisions, and

WHEREAS, These medical decisions affect the general welfare, death benefits and administration of justice, and

WHEREAS, Physicians are by their knowledge and training the only persons capable of making medical decisions, now, therefore, be it

Resolved, That the Mississippi State Medical Association state its belief that Coroners should be licensed doctors of medicine, and be it further

Resolved, That the Mississippi State Medical Association seek appropriate legislation to accomplish this objective.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee gave careful consideration to Resolution No. 2, introduced by the Delegate from Adams County. This resolution seeks the association's endorsement of legislation to provide that coroners must be licensed doctors of medicine. Your reference committee notes that the present coroner system in Mississippi qualifies us to be listed by the National Municipal League as one of the "easiest states in which to commit a murder." Your reference committee believes that the legislation proposed in Resolution No. 2 would go a long way towards correcting this unfortunate classification and, therefore, strongly recommends its adoption.

The report of the reference committee was adopted.

RESOLUTION NO. 3, STANDARD HIC CLAIM FORMS

Dr. W. B. Winstead: WHEREAS, The cost and time consumed by hospitals and physicians in completing multiple varied insurance claim forms requested by the many individual insurance carriers has increased considerably over the last few years, and

WHEREAS, There is an increasing need to attempt to reduce cost to the patient of medical care and all its ancillary aspects by improving the efficiency of medical care and administration as much as possible, and

WHEREAS, The Singing River Hospital Medical Staff and Singing River Hospital Administration, seeking to facilitate increased efficiency in this area, adopted on January 1, 1968, a "Standard insurance claim form program" whereby the members of the staff and the hospital have agreed to complete only the Standard Health Insurance Council-approved and AMA Council of Medical Services-approved form of 1964, for all health insurance claims with the exception of claims submitted by the hospital to carriers with whom the hospital has a contract (such as U. S. Public Health Service, Vocational Rehabilitation, etc.), and

WHEREAS, The adherence to this program has greatly increased the efficiency of handling insurance claim forms by reducing the work required and by reducing the manhours required in preparing these forms significantly, such that the hospital was able to reduce the number of insurance clerks by one full employee, and the physicians on the staff have experienced improved efficiency within their offices, and

WHEREAS, The insurance carriers doing business within the area served by the Singing River Hospital, except Blue Cross-Blue Shield, have given enthusiastic support and endorsement of this plan, and this resolution has been adopted by the Coast Counties Medical Society, now, therefore, be it

Resolved, That the Mississippi State Medical Association recommend to all of its component medical societies that they strongly consider adopting a similar program in their respective areas immediately, and be it further

Resolved, That all health insurance carriers doing business within the state of Mississippi be so informed that this is the official policy by the Mississippi State Medical Association.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 3, introduced in behalf of the Coast Counties Medical Society. This resolution in essence recommends that the association officially approve the standard health insurance claim form developed by the Health Insurance Council and the AMA Council on Medical Services. During discussion of this resolution it was pointed out to your committee that the House of Delegates officially endorsed the HIC-AMA approved uniform claim form in 1960. Your reference com-

mittee, therefore, recommends that the House of Delegates reaffirm and stress its prior action in this regard and that appropriate publicity be given to this action in our JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION. Furthermore, your reference committee recommends that this action be communicated to the secretaries of our component medical societies and that they be urged to establish appropriate liaison with local representatives of the health insurance industry to insure their knowledge and understanding of the HIC-AMA Uniform Claim Form.

The report of the reference committee was adopted.

RESOLUTION NO. 4, EMBLEM OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

Dr. H. C. Ricks and Dr. Lawrence W. Long: WHEREAS, The Past Presidents of the Mississippi State Medical Association voted to present the association with a flag bearing the crest or emblem of the association and an American Flag, both for permanent display in our central office headquarters building, and

WHEREAS, We have been informed that this project should be held in abeyance, because the association's long-standing and traditional emblem is to be recommended for change by the Board of Trustees and general officers, and

WHEREAS, Our present emblem has represented our association for nearly 20 years and is used extensively in our JOURNAL, on our membership cards, on all printing, on all our official transactions, and is cast in metal and stone in our central office headquarters building, and

WHEREAS, This emblem has become the familiar insignia of our association with deep meaning through long tradition, custom, and usage, and

WHEREAS, It has been altered only once, by official action, for the purpose of representing our Centennial Observance in 1956 by including the dates on the scroll for that year only, and

WHEREAS, A change in this emblem would involve a loss in our history, tradition, and custom, and

WHEREAS, The altering of the emblem would entail an expenditure which we can ill afford, now, therefore, be it

Resolved, That the Mississippi State Medical Association does reaffirm its approval of its emblem of long-standing by this action of the House of Delegates.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Resolution No. 4 introduced by Drs. H. C. Ricks and Lawrence W. Long, past presidents, proposes reaffirmation of the approval of the emblem of the Mississippi State Medical Association. Earlier in the year, the Board of Trustees considered making a change in this emblem, but the Board has advised your Reference Committee that it has reversed its position in this connection. Your Reference Committee approves the resolution and recommends its adoption.

The report of the reference committee was adopted.

RESOLUTION NO. 5, AMENDMENT OF PUBLIC HEALTH LAWS

Dr. Stanley A. Hill: WHEREAS, The Mississippi Legislature in its 1966 Regular Session enacted an amendment to the Public Health Laws providing for appointment of an optometrist to membership on the Mississippi State Board of Health, and

WHEREAS, This post is unnecessary and undesirable, inasmuch as there is a Mississippi State Board of Optometry already provided for in law, and

WHEREAS, It is in the interest of the people of Mississippi to abolish the post of the optometrist on the State Board of Health, now, therefore, be it

Resolved, That the Mississippi State Medical Association actively seek repeal of the provision in the Public Health Laws of the state which provides for appointment of an optometrist to the State Board of Health.

REPORT OF THE REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your reference committee considered Resolution No. 5, introduced by a past president of our association. During the 1966 Regular Session of the Mississippi Legislature, a law was enacted which placed an optometrist on the Mississippi State Board of Health. Resolution No. 5 urges the association to actively seek repeal of this provision and your reference committee recommends its adoption. We stress in this regard, however, that it will take the same type grassroots support by our association to repeal this law as provided by the association which got the law passed in 1966.

The report of the reference committee was adopted.

RESOLUTION NO. 6, STATEWIDE TETANUS EDUCATION AND IMMUNIZATION PROGRAM

Dr. Raymond S. Martin, Jr.: WHEREAS, Mississippi has been one of the states leading the nation in numbers of cases reported in recent years: 1966—14 cases—12 deaths—85% mortality; 1967—10 cases—8 deaths—80% mortality;

(1956-1966—157 cases—108 deaths—69% mortality), and

WHEREAS, This potentially fatal disease can be successfully prevented by active immunization with three doses of tetanus toxoid, as proved by widespread military experience, and

WHEREAS, The majority of our younger population receive this protection with infant immunization programs, yet tetanus and death occur in the large segment of our adult population in whom there has been no protection, and

WHEREAS, Passive immunization with equine and bovine antitoxin are condemned for the high incidence of associated serum reactions, and passive immunization with human immune globulin is expensive and of short, non-permanent duration, and

WHEREAS, The trauma committee of the Mississippi Chapter, American College of Surgeons, has studied this problem, conferred with the State Board of Health, and desires to carry out a statewide education and immunization program against tetanus, now, therefore, be it

Resolved, That the House of Delegates of the Mississippi State Medical Association urge its component medical societies and each of its members to support such a statewide education and immunization program.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 6, introduced in behalf of the Central Medical Society. This resolution notes that the Trauma Committee of the American College of Surgeons and the Mississippi State Board of Health have studied this problem and now wish to carry out a statewide education and immunization program against tetanus. In discussion before your committee it was further pointed out that a number of communities in the state had already conducted successful tetanus immunization programs. Your reference committee urges adoption of Resolution No. 6 and further recommends that appropriate publicity be given this subject in the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION.

The report of the reference committee was adopted.

NOMINATING COMMITTEE

At the adjourned meeting of the House of Delegates on May 16, 1968, Dr. Eldon L. Bolton of Biloxi, noting the action to provide for the Nominating Committee a year in advance of the annual session at which its nominees would be voted on, moved that the House now proceed to select a Nominating Committee, severally seconded. Dr. Guy T. Vise of Meridian made a substitute motion to make use of the committee named in the district caucuses on May 13, 1968, second Dr. Lamar Arrington of Meridian. There being no further discussion, the Speaker put the substitute motion which was adopted, thereby disposing of the main motion.

Dr. Walter H. Simmons of Jackson, the Secretary-Treasurer, asked that the action be publicized through the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION.

COMMENDATION OF COUNCIL CHAIRMAN

Noting that Dr. Guy T. Vise of Meridian is retiring as chairman of the Council on Medical Service, Dr. William E. Lotterhos, the Speaker, asked that the House of Delegates join in commending Dr. Vise for his leadership and service, and the House responded with applause.

ADDITIONAL BUSINESS OF THE HOUSE OF DELEGATES

The 1968 MSMA-Robins Award for outstanding community service by a physician was presented to Dr. W. H. Anderson of Booneville by the President, Dr. Ainsworth. Dr. Walter H. Simmons presented the Aesculapius Award and an honorarium of $200 to Dr. Thomas L. Kilgore, Jr., of Jackson and to his colleagues at the Surgical Clinic in behalf of the Council on Scientific Assembly for having presented the scientific exhibit adjudged most outstanding.

The association's Scientific Achievement Award for the scientific exhibit adjudged most outstanding by a guest exhibitor was presented to Dr. Charles Pearce of the Tulane University School of Medicine, New Orleans.

The chairman of the Board of Trustees, Dr. John B. Howell, Jr., presented the association's Scientific Achievement Award to Smith, Kline and French Laboratories for it contribution to scientific communication, especially through its medical color television unit. The award was received by Mr. J. Somers Smith of Philadelphia, vice president of SKF, who expressed the appreciation of his company. Dr. Howell noted that this was the first and only occasion when the award had been made to other than a physician.

Mrs. David L. Clippinger of Hazlehurst, 1967-68 President of the Woman's Auxiliary to the Mississippi State Medical Association, and Mrs. Paul B. Brumby of Lexington, 1968-69 President, addressed the House of Delegates.

There were no reports by fraternal delegates.

OFFICIAL ATTENDANCE

The official attendance was announced as being 941 to include 550 physicians, both members and guests, 210 members of the Woman's Auxiliary, 16 residents, nine interns, 32 medical students, 115 exhibitors, and nine staff members.

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

Conduct of Business. Your reference committee commends the Speaker and Vice Speaker for the outstanding manner in which they have conducted business before this House of Delegates. We believe that all members will wish to associate themselves in this connection and an expression of appreciation to these officers.

Resolution. Your reference committee desires to offer the following resolution for consideration by this House of Delegates:

WHEREAS, The 100th Annual Session of the Mississippi State Medical Association has been conducted at Jackson, Mississippi, during the period May 13-16, 1968, and

WHEREAS, The annual session has been most profitable and enjoyable for all who have been in attendance, now, therefore, be it

Resolved, That expressions of deep appreciation are made to the officers, Trustees, and Council on Scientific Assembly for the stimulating and useful scientific program; to the management of all participating hotels, particularly to the Heidelberg, the headquarters hotel; to the press, radio, and television for coverage of our activities; to the gracious ladies of the Auxiliary who always contribute so substantially to our meetings; to the technical exhibitors and their professional service representatives; to the scientific exhibitors; to our distinguished guests; and to all who shared in the responsibilities of planning, organizing, and conducting this great annual session, and be it further

Resolved, That your House of Delegates unanimously, heartily, and enthusiastically commend Smith, Kline and French Laboratories for its priceless contribution to the scientific work of our association in furnishing the services of its medical color television unit.

Your reference committee recommends adoption of this resolution.

The report of the reference committee was adopted.

REPORT OF THE ELECTION OF OFFICERS

President-elect: James L. Royals, Jackson.

Vice Presidents: Jack A. Stokes, Pontotoc; George H. Martin, Vicksburg; Charles R. Jenkins, Laurel.

Associate Editor: George H. Martin, Vicksburg.

Delegate to AMA: Howard A. Nelson, Greenwood.

Alternate Delegate to AMA: Stanley A. Hill, Corinth.

Board of Trustees: Mal S. Riddell, Jr., Winona, District 4; William O. Barnett, Jackson, District 5; Guy T. Vise, Meridian, District 6.

Council on Budget and Finance: J. T. Davis, Corinth.

Council on Medical Education: William O. Barnett, Jackson.

Council on Constitution and By-Laws: Raymond S. Martin, Jr., Jackson.

Council on Legislation: John G. Egger, Drew, District 1; James L. Thornton, New Albany, District 2; Frank M. Davis, Corinth, District 3.

Judicial Council: Frank M. Acree, Greenville, District 1; Rhea L. Wyatt, Holly Springs, District 2; Arthur E. Brown, Columbus, District 3.

Council on Medical Service: Paul B. Brumby, Lexington, District 4; John G. Caden, Jackson, District 5; William M. Gillespie, Meridian, District 6.

Board of Trustees of Mental Institutions: J. A. K. Birchett, Vicksburg; Eldon L. Bolton, Biloxi; C. P. Crenshaw, Collins; Martin E. Hinman, Vicksburg; Victor E. Landry, Lucedale.

CONSTITUTION AND BY-LAWS

At the close of business, there were no pending amendments to the Constitution or By-Laws.

CLOSING CEREMONIES

There being no further business, the Speaker returned the gavel to the President, Dr. Ainsworth. The Oath of Office was administered to Dr. Joseph B. Rogers, the President-elect, by Dr. John B. Howell, Jr., Chairman of the Board of Trustees after which Dr. Rogers addressed the House of Delegates.

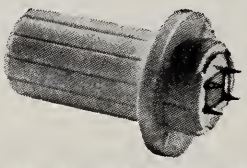
Dr. James Grant Thompson presented the Thompson Memorial Past President's Pin to Dr. Ainsworth.

The House of Delegates was adjourned *sine die* at 4:19 o'clock in the afternoon, May 16, 1968.

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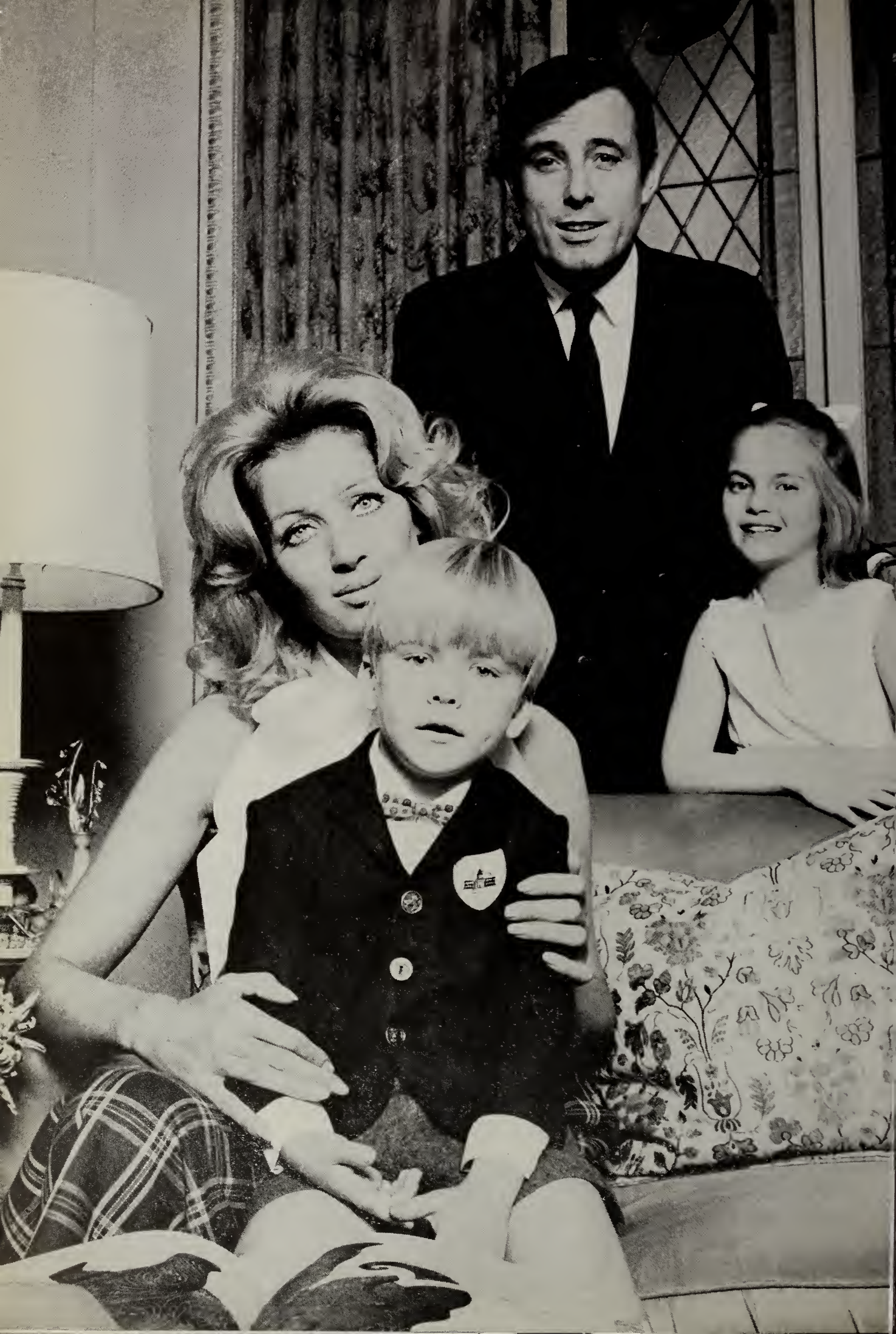
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pinworms in this family?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections in primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes group therapy entirely practical, convenient, and economical.

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Vitamin B_6	7.5 mg
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* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

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Rx Drug Prices Hit 18-Year Low

The long-range decline in prescription drug prices continued in 1967, according to C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association.

The comprehensive index of prices at manufacturers' levels, prepared by Dr. John F. Firestone of the City University of New York, shows a 1967 price level of 85.2 as compared to the 1949 base of 100, Mr. Stetler reported.

"The index declined from 85.9 to 85.2 in 1967, reaching its lowest point in eighteen years," Stetler noted. "This is a rather unique phenomenon in an era of climbing prices."

Dr. Firestone said that the government's Bureau of Labor Statistics Wholesale Price Index actually shows a greater decline than his more inclusive study, which he has prepared for several years under PMA sponsorship. Since its revision and expansion in 1961, he explained, the Bureau of Labor Statistics (BLS) Index has dropped 8.2 per cent as against 5 per cent under the Firestone index.

The BLS Consumer Price Index for prescription drugs at retail has also declined sharply. By December, 1967, it stood 11.6 per cent below the 1957-59 base, while the overall cost of living (all-items Consumer Price Index) rose 18.2 per cent during the same period.

"This spread between drug prices and other prices has continued to grow," Stetler said. "In March, 1968, the all-items Consumer Price Index had risen to 119.5 Meanwhile, the prescription drug component had dropped to 87.8."

The PMA president pointed out that price reductions have been especially noteworthy in antibiotics, which, because of their importance in the total market, carry a relatively heavy weight. Dr. Firestone found that antibiotics had declined 8.5 per cent between 1966 and 1967, more than off setting increases in some of the less important categories, such as dermatologicals. His index also delineated the stability of prices for diuretics, tranquilizers, sedatives, sulfonamides, antiarthritics, and hematinics.

Stetler also noted that price declines have occurred, in recent years, in such major categories as tranquilizers, cardiovasculars, and steroids, including the oral contraceptives.

"These price cuts reflect the capability of the industry, as products gain in volume, to produce, promote, and distribute them more efficiently," Stetler said. "Consequently price cuts have been achieved in a market situation marked by rela-

tively keen competition and a relatively low degree of concentration. No company has as high as 7 per cent of the total market."

"In addition," he said, "the rate of concentration has been decreasing and with it the average market share of leading producers. Under these conditions it is not surprising that one of the largest broad-line, research-oriented manufacturers announced not long ago that its prices have declined almost 12 per cent in 12 years."

The 1967 Firestone index shows a decline of 1.0 per cent for patented products, while non-patented items dropped only 0.05 per cent. Prices on patented items have fallen to 74.5 per cent of the 100 base, while the non-patented ones stand at 101.1 per cent of the 1949 base.

"These statistics do not support the theory that patents are responsible for maintaining price levels," Stetler said. "On the contrary, in the field of pharmaceuticals, there is strong cross competition among different products treating the same disease. A patent provides only partial, and not necessarily long-lasting, protection."

The complete Firestone study is available on request from the Pharmaceutical Manufacturers Association.

IUD Film Is Available to Societies

A new medical teaching film, widely distributed overseas, entitled "Insertion and Removal of an Intra-Uterine Device (IUD)" is now available in 8 mm sound MoviePak cartridges for use by physicians and medical students.

Produced at the University of Washington School of Medicine, Department of Obstetrics and Gynecology, by Drs. George C. Denniston and Walter L. Herrmann, the 11-minute color film can be used for individual instruction and classroom use with the aid of a Fairchild Mark IV rear screen sound movie projector. The film was sponsored through a grant given by the Population Council.

According to Dr. Denniston, "The film takes the audience step by step through the relatively simple procedure of utilizing this birth control device, and demonstrates ways to avoid physical harm. The film is ideally suited for medical student training in contraceptive techniques." A medical pamphlet, Care of the Patient With an IUD, is also available. Dr. Denniston, film narrator and author of the pamphlet, is now associate medical director of Planned Parenthood—World Population.



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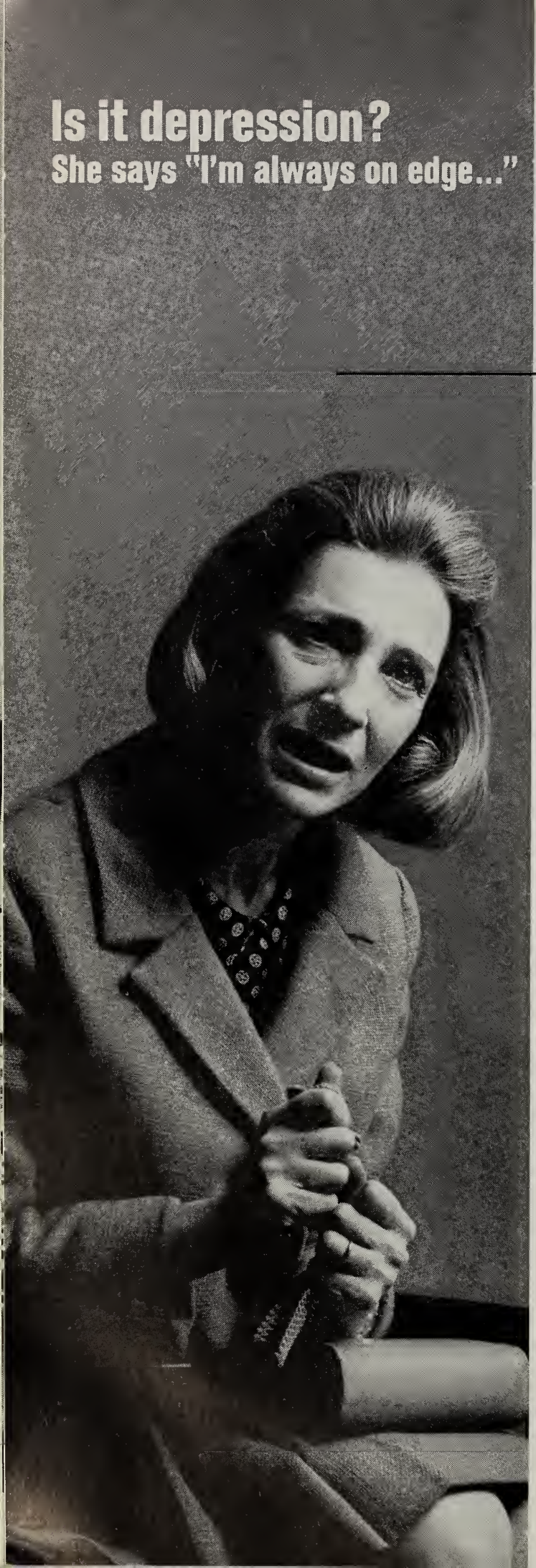
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Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

September 1968

Dear Doctor:

Mississippi Blue Cross-Blue Shield has been asked by State Insurance Commission to refund up to $1.25 million to senior contract holders. Action was said to have come about as a result of the plan's "carving out" Medicare benefits received by contract holders under Parts 1-A and 1-B without also reducing premiums.

> The Commercial Appeal said that Insurance Commission's action is backed by the Attorney General of Mississippi. Plan held special meeting of board of directors in August on this matter and over relations with state medical association following withdrawal of approval at 100th Annual Session.

A seedling from Hippocrates's plane tree on the Isle of Cos has been given the University of Alabama Medical Center at Birmingham. The legendary tree, said to be about 2,400 years old, under whose branches the father of modern medicine taught his students, is distantly related botanically to the sycamore. A Greek physician arranged for the gift.

Rising incidence of hepatitis has resulted in an order from National Institutes of Health halting interstate shipment of pooled blood plasma. Order was directed to processors who handle about 300,000 units annually when it was found that one out of 10 receiving pooled plasma develops hepatitis. NIH believes use of whole pooled plasma should be discontinued.

Professional fees charged by radiologists have increased only 5 per cent in two years against an overall increase of 14 per cent for all doctors. This is the finding of the American College of Radiology, taking as baseline cost for PA and lateral chest films and interpretation, going to a mean of $15.80 in 1968 to $15.05 in 1966. ACR says that in same period, hospital costs have advanced 30 per cent.

Membership in the Mississippi State Medical Association may reach a record high in 1968. As of mid-August, association had a higher membership than total for entire year of 1967 with 1,264 paid, 62 Emeritus, and 43 exempt from dues for other reasons, a total of 1,369. Association growth is index to growing profession in state.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Ciba Will Build Plant In Mississippi

Jackson - Officials of the Ciba Corp., parent group of Ciba Pharmaceuticals, announced jointly with Governor Williams that organization will build a major chemical plant at Lake Cormorant, Miss., on the river north of Clarksdale. Area is also served by IC Railroad and Interstate 55. Early estimates say plant will be in "multi-million dollar" bracket and bring new and important job opportunities to northern portion of state. Only one other drug plant is located in state, Baxter Laboratories.

Viet Nam Volunteer Program Is Hailed As Successful

Chicago - In its first comprehensive report on the Volunteer Physicians for Viet Nam, AMA says that 483 tours of 60 days have been served by 450 American volunteer physicians. Twenty-five have served two tours, and four returned to serve three tours each. The doctors have come from 49 states and D.C., with only Rhode Island in the zero column. Dr. Tom H. Mitchell of Vicksburg served a tour in the spring, representing Mississippi. Program needs 32 volunteers every 60 days, usually GP's, internists, pediatricians, and general surgeons. Most critically needed are orthopaedic surgeons and ophthalmologists.

NIH Tests New Concept In Heart Valves

Bethesda - The National Institutes of Health report that an artificial heart valve employing, of all things, a jeweled bearing and an airfoil promises new successes. Tests in laboratory animals show greater durability and less tendency to engender blood clots than bulky caged-ball valves in current clinical use. Made entirely of rigid components, new valve offers only half the resistance to forward blood flow as present prostheses.

Delaware Becomes Fourth State To Fluoridate

Wilmington - Delaware's legislature passed the fourth compulsory fluoridation law which became effective recently. New statute amends public health laws and makes fluoridation a duty of state board of health. Previously, laws have been passed in Connecticut, Minnesota, and Illinois. Kentucky and Michigan have board of health-ordered fluoridation, but both are experiencing difficulties from quack opponents and others.

Discharged Patient Is Held To Be Trespasser

Washington - The U.S. Circuit Court of Appeals may have put new meaning into utilization review by holding that a patient discharged from a hospital and who insisted on remaining is a trespasser, despite the ability to pay for continued hospitalization. Court said that the hospital has a moral duty to reserve accommodations for those needing care. Citation is L. W. Hayes National Training School for Deaconesses and Missionaries v. Geoghegan, 281 F. Supp. 116 (D.C., D of C., June 28, 1967).

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

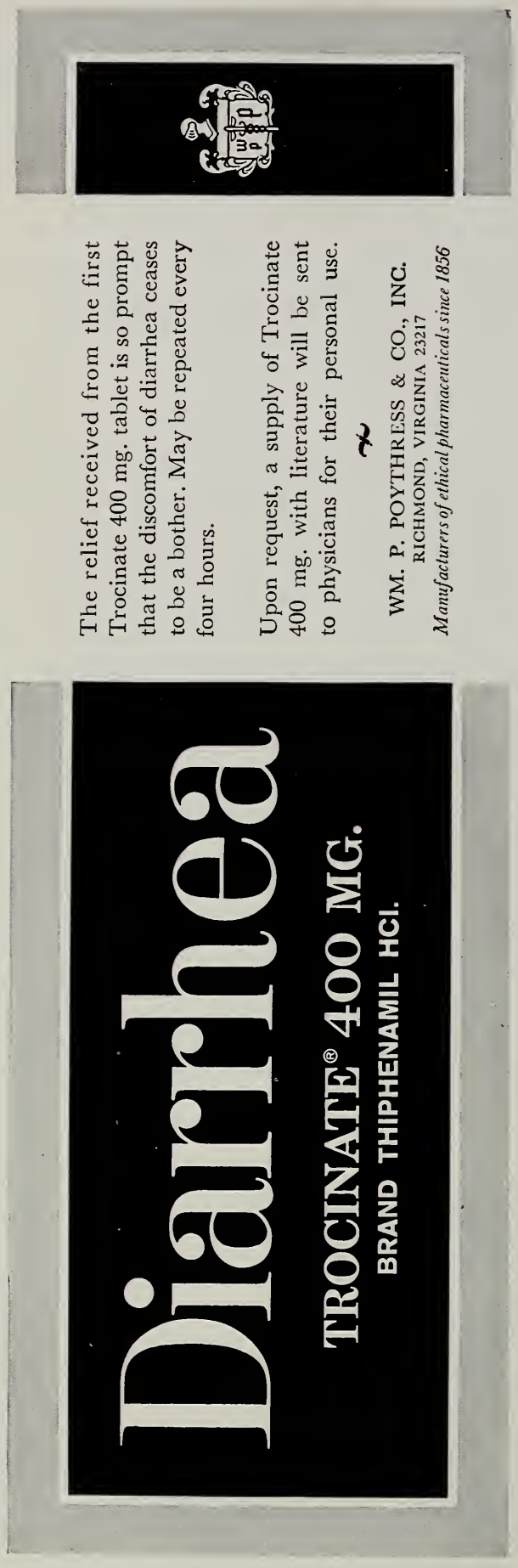
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Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

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407-8



AMA Sets Guides for Organ Transplants

Ethical guidelines concerning organ transplants, submitted by the AMA's Judicial Council, were approved by the House of Delegates at the 1968 Annual Convention in San Francisco.

According to the Judicial Council's opinion, "A man in the final analysis, must make a decision whether to permit or to perform a transplantation procedure. The decision must be a reasoned, intellectual decision, not an emotional decision. As medical science advances, and as technological skill increases, the ethical questions involved may become increasingly complex and difficult."

The Council offers the following statements for the guidance of physicians as they seek to maintain the highest level of ethical conduct in their practice.

Since the physician's primary concern is the health of his patient, care must be taken to protect the rights of both the donor and the recipient, and no physician may assume the responsibility in organ transplantation unless the rights of both donor and recipient are equally protected.

A prospective organ transplant offers no justification for relaxation of the usual standards of medical care. Hence, the physician should provide a prospective organ donor with the same care usually given others being treated for similar injury or disease.

When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician, using all available, currently accepted scientific tests.

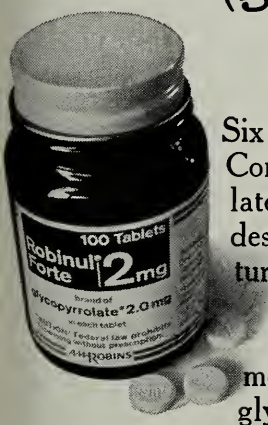
There should be full discussion of the proposed procedure with the donor and the recipient or their responsible relatives or representatives. The physician's interest in advancing scientific knowledge must always be secondary to his primary concern for the patient.

Transplantations should be undertaken only by physicians who possess special medical knowledge and technical competence and in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

Transplants should be undertaken only after careful evaluation of the availability and effectiveness of other possible therapy.

Discreet public reports to the communications media may be made by a properly authorized physician but should be followed as soon as possible by full scientific reports to the profession.

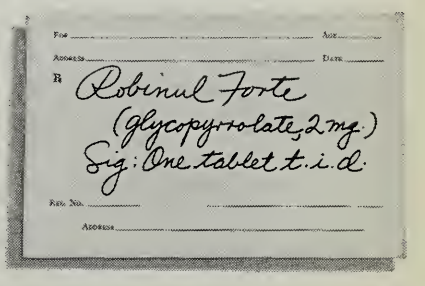
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

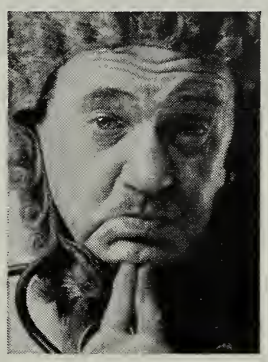
However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

Graflex Will Operate Delta Poverty Project

Graflex, Inc., a subsidiary of General Precision Equipment Corp., has received a two year contract from the Delta Resource Development Corporation to operate a rehabilitation and training center at Greenville. The agreement follows a study and planning contract with the Mississippi Research and Development Center since Sept. 1967 for such a center. Expenditures under the two year contract could exceed $10 million.

Under terms of this contract, Graflex will establish and operate a training and rehabilitation center in buildings which formerly housed Greenville Air Force Base, a technical training base, deactivated in 1965. The majority of clients for the center are expected to come from the Delta counties near Greenville, although any Mississippian meeting Vocational Rehabilitation Administration client requirements is eligible.

A comprehensive training program developed by Graflex forms the foundation of the effort to begin to equip the large number of poverty-stricken residents in the region with employable skills and a basic education. The program will also strive to mesh this upgrading of manpower skills among the population with concurrent efforts at industrial development for the area.

The region immediately affected by the Delta Resource Development Center is a section of the "cotton belt" region of the Mississippi Delta in the northwest portion of the state. This area, of which Greenville is a major population center, has experienced economic decline which has affected many of its 220,000 residents. Unemployment estimates range anywhere from 5 to 18 per cent, but it is thought by Graflex that these figures underestimate the problem.

According to the 1960 census, 63 per cent of the Delta families receive incomes below $3,000 and 27 per cent, below $1,000. And, though jobs are available in the area, most of the people to be aided by this program do not have sufficient entry level skills to take advantage of these openings.

The Ford Foundation has provided a "start-up" grant of $500,000 to the Mississippi Research and Development Center. This money was in turn channeled to Vocational Rehabilitation Division of the State Department of Education and used by that agency as "matching funds" to acquire an initial federal vocational rehabilitation grant of $3.5 million for the center.



THE BRADLEY CENTER

An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

Brochures and rate schedules are available on request.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen.(Ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
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Area Code 404 - 324-4882

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
September 1968, Vol. IX, No. 9

ORIGINAL PAPERS

Current Concepts Of Tetanus Immunization

RAYMOND S. MARTIN, JR., M.D.
Jackson, Mississippi

TETANUS, WITH ITS high morbidity and mortality rates, is an ever-present threatening complication to deep, contaminated wounds. It is not uncommon for tetanus to develop in a neglected or forgotten trivial wound. A Mississippi state senator died several years ago when tetanus followed a minor scratch from barbed wire. Cases have been reported following peritoneal contamination due to gangrenous appendicitis. One-third of clinical cases of tetanus fail to show the site of entrance of the tetanus bacillus.[6]

One hundred years ago, during the Civil War, the U. S. Army recorded 280,040 admissions for wounds and injuries (Table 1).

TABLE 1

INCIDENCE OF TETANUS IN THE UNITED STATES ARMY

	Admissions for Wounds & Injuries	*Cases of Tetanus*	*Cases/100,000 Wounds & Injuries*
Civil War	280,040	505	18.03
World War I ..	523,158	70	13.4
1920-1941* ...	580,283	14	2.4
World War II .	2,734,819	12	0.44

* Inclusive

There were 505 cases of tetanus with fatalities of 451—or 89.3 per cent. Little was known about the prevention and treatment. Treatment consisted of primary wound care, nonspecific medications and amputations—yet nine out of ten patients died with the disease.[2]

Mississippi, Florida and Louisiana continue to lead the nation in tetanus cases reported. Mississippi's cases average from 12 to 20 per year. The author reviews the present principles of prophylaxis. He discusses the program for education and immunization planned by the Trauma Committee of the Mississippi Chapter of the American College of Surgeons.

Seventy-seven years ago, 1890, von Behring and Kitasato discovered tetanus antitoxin and successfully demonstrated its use in laboratory animals. Ten years later equine antitoxin was advocated for treatment and prophylaxis in humans. (Table 2).

It was not until 14 years later that military medicine led the widespread adoption of equine tetanus antitoxin. Within a three-month period the British Army was able to reduce the incidence of tetanus from nine cases per 1,000 wounded in

Chairman, Committee on Trauma, Mississippi Chapter, American College of Surgeons.
Read before the Central Medical Society, Jackson, Miss., Jan. 2, 1968.

September, 1914, to 1.4 cases per 1,000 in December, 1914.

In 1924, the antigenic effect of tetanus toxid was first demonstrated. Considering its outstanding efficiency, its excellent record of safety, the long duration of protection and the ability of the individual to respond to booster doses for an even longer period of time, it is probably one of the best immunizing agents available for disease control. Army experience with toxoid, prior to World War II, successfully reduced tetanus cases; however, it was this second World War that convinced the profession of the value of toxoid, just as World War I proved the value of tetanus antitoxin.

Most physicians are familiar with the widely quoted study of the Battle for Manila. Among 12,000 wounded civilians, not believed to have had tetanus prophylaxis prior to injury, 473 cases developed tetanus—an incidence of almost 4 per cent—with an associated death rate of 82 per cent (Table 3).

TABLE 2

EVOLUTION OF TETANUS PROPHYLAXIS

100 yrs. ago	Primarily wound care—at best, poor
77 yrs. ago	1890—von Behring and Kitasato—successful laboratory use of antitoxin
67 yrs. ago	1900—Approval and adoption of equine antitoxin for treatment and prophylaxis in humans
53 yrs. ago	1914—World War I opportunity to demonstrate effectiveness of passive immunization
43 yrs. ago	1924—Tetanus toxoid
22 yrs. ago	1945—World War II experience with toxoid
3 yrs. ago	1965—Human immune globulin production

TABLE 3

BATTLE FOR MANILA—1945

Philippine Civilians—1945	*vs.*	*Total U.S. Army Experience World War II*
12,000 wounded civilians		2,734,819 admissions for wounds and injuries
No tetanus prophylaxis		
473 cases tetanus		12 cases tetanus
Incidence rate 4%		Incidence rate 0.00044%
Mortality rate 82.1%		Mortality rate 41.7%

By contrast, the total World War II experience of the United States Army was only 12 cases of tetanus in a compiled series of 2,734,819 hospital admissions for wounds and injuries—an incidence of 0.00044 per cent (forty-four ten thousandths of one per cent) with an associated mortality rate of only 41.7 per cent[8] (Table 4).

TABLE 4

WORLD WAR II IMMUNIZATION

Tetanus, United States Army, World War II	*Fatal Cases*	*Total Cases*
No active immunization	2	6
Initial immunization (three injections of fluid toxoid) accomplished but no emergency stimulating injection given	1	2
Initial immunization plus emergency stimulating injection given	2	4
Total	5	12

Tetanus toxoid immunization status of 12 cases of tetanus in 2,734,819 United States Army hospital admissions during World War II.

These Army statistics reflect a relatively controlled situation, where immunization can be compulsory. They are unfortunately a sharp contrast to the current picture in our civilian population.

The U. S. Public Health Service reported in the nation, 272 cases of tetanus in 1965, and 235 cases in 1966—the deaths each year corresponding to 66 per cent of the total. In Mississippi, the 10-year period from 1956 to 1966 accounted for 157 deaths, or an average of 15.7 per year, with a fatality rate of 69 per cent. In 1958, there were 25 cases and 16 deaths with 64 per cent mortality and in 1966, there were 14 cases and 12 deaths with 85.7 per cent mortality[5] (Table 5).

TABLE 5

INCIDENCE OF TETANUS

	Cases	*Deaths*	*Fatality Rate* PER CENT
Miss.			
1956-66	157	108	69
1966	14	12	85.7
1967	9+	7+	—
U.S.			
1965	272	181	66
1966	235	156	66
1967	223+	—	—

In spite of our technological advances in this field, and though the incidence of the disease is small, in our state and in the nation, tetanus, like rabies, is still a deadly disease—a killer. Contrasted to the mortality rate of 89 per cent, one hundred years ago, our national average is 66 per cent and in Mississippi in 1966, 85 per cent of the people who contracted this disease succumbed.

Tetanus is a preventable disease, and it is the responsibility of every physician in this state to do what we can to prevent it. There are two studies which tend to emphasize the problem with which we deal in Mississippi, and in fact, throughout the nation.

MISSISSIPPI SURVEY

1. Several years ago 1,200 consecutive admissions for trauma to the emergency room of a Columbus, Ohio, hospital revealed that the following had not had adequate active immunization prior to injury: 1 of 25 boys; 1 of 12 girls; 1 of 4 adult men and 1 of 2 adult women.[3]

2. An immunization survey in Mississippi in 1963 and 1964 revealed that approximately 30 per cent of the population less than five years of age were not actively immunized for tetanus.

MISSISSIPPI IMMUNIZATION SURVEY
1963-1964
POPULATION NOT IMMUNIZED FOR TETANUS

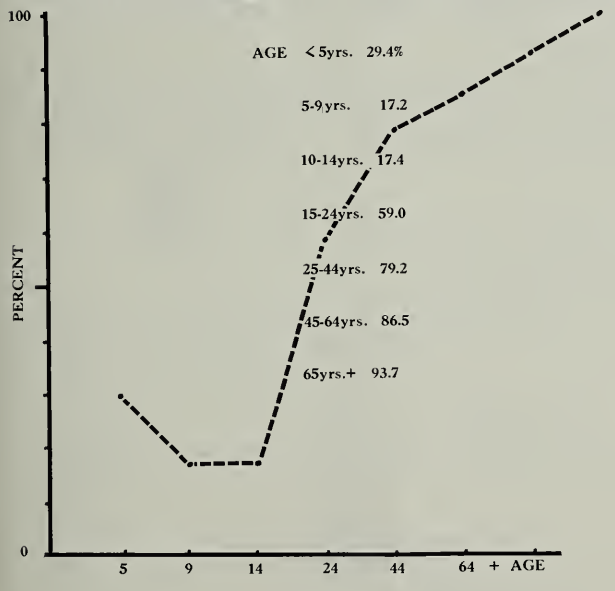


Figure 1

Note that in the age groups five to nine and ten to fourteen years, only 17 per cent were not immunized. This reflects an emphasis being made by the health department to control communicable diseases in young school children. From 15 years upward, the percentage of the population not protected "takes off" like a saturn rocket.

There are multiple explanations for this state of affairs. Military service during and since World War II has insisted on immunization of a large segment of the young male adult population. The state program for school children has covered another important segment. Since the 1963-64 study, state health department clinics have supervised the births of about 23,000 per year and have carried out immunization of approximately half of our new population in the past few years. At the present time, tetanus toxoid in combination with diphtheria, whooping cough and polio is available to infants and children in Mississippi County Health Units. Tetanus and diphtheria boosters are also available for children and adolescents to age 18.

Of the 12 deaths from tetanus during 1966, two were under 1 year of age and 10 were over 35 years. The target group for prophylactic immunization in the state should be the adults. Mississippi is still a primarily agricultural state and wound contamination with the tetanus spore is most vulnerable in rural areas. We are rapidly becoming an industrialized state, and protective immunization can be readily carried out in controlled groups here. Our ever mounting highway accident rate, 908 in 1967, suggests that every citizen is a statistical candidate for a deep contaminated wound.[9]

TASK FOR PHYSICIANS

The State Health Department is limited in its ability to provide preventive measures so widespread to eliminate a disease that affects only 15 to 25 persons per year yet these are potentially 12 to 20 deaths per year which can be prevented. The Trauma Committee of the Mississippi Chapter of the American College of Surgeons has for several years sought to direct the attention of every Mississippi physician to the importance of an education and prophylactic immunization program. Unlike polio, we cannot attract the population to medicine on sugar cubes at the neighborhood or county school. We have to sell a program of three well-timed needle injections to a calloused cowardly adult group. And this, except for large industrial groups, can best be done only in the office of the private physician.

Tetanus must be moved into the proper prevention depot—the doctor's office. As a starter, how many physicians include in their history-taking for routine patients an inquiry regarding tet-

Prophylaxis Against Tetanus in Wound Management

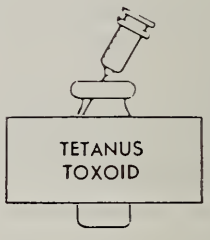
COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS

General Principles

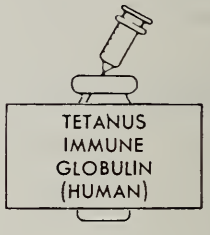


I. *Attending physician must determine for each patient what prophylaxis for tetanus is required.*

II. Regardless of active immunization status of patient, *meticulous surgical care, including removal of all devitalized tissue and foreign bodies, is to be provided immediately to all wounds.* Such care is essential.



III. *Every patient should receive tetanus toxoid intramuscularly* at the time of injury, as an initial immunizing dose, or as a booster for one previously immunized, unless he has received a booster or has completed his initial immunization within the past 12 months. As the antigen concentration varies in different products, specific information on the volume of a single dose is provided on the label.

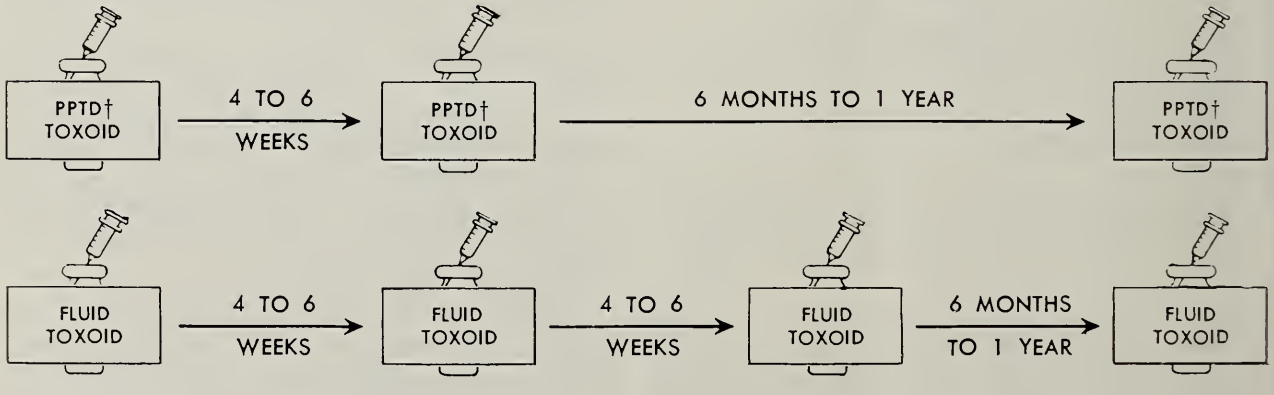


IV. *Whether to give human tetanus immune globulin or equine tetanus antitoxin for passive immunization must be decided for each patient.* Wound, conditions under which it was incurred, and previous active immunization status must be considered.



V. *To every wounded patient give a written record of immunizations,* instructing him to carry record and, if necessary, to complete active immunization.

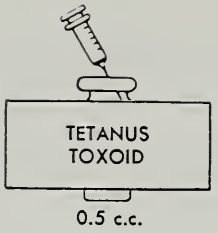
VI. Basic immunization with precipitated (PPTD) toxoid requires three injections; and with fluid toxoid four injections.



†*Precipitated*

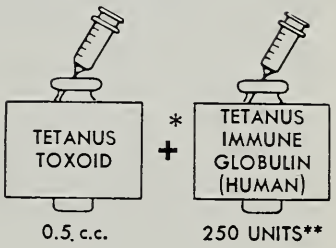
Previously Immunized Individuals

A. When the *patient has been immunized within the past six years,* give 0.5 c.c. tetanus toxoid booster.



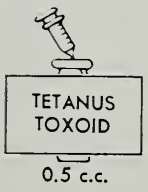
B. When the *patient has been immunized more than six years,*

1. To the great majority only give 0.5 c.c. of tetanus toxoid.
2. To those with wounds which indicate an overwhelming possibility that tetanus will develop,
 a) Give* 0.5 c.c. of tetanus toxoid,
 b) Give* 250 units of human tetanus immune globulin,**
 c) Consider use of oxytetracycline or penicillin.



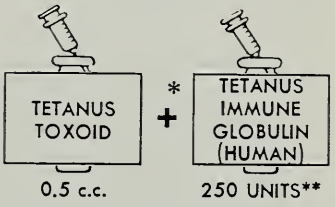
Individuals NOT Previously Immunized

A. For *clean minor wounds* in which tetanus is unlikely, give 0.5 c.c. of tetanus toxoid (initial immunizing dose).



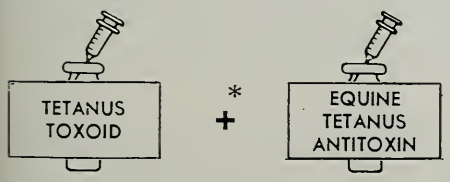
B. For *all other wounds*
 1. Give* 0.5 c.c. of tetanus toxoid (initial immunizing dose),
 2. Give* 250 units of human tetanus immune globulin,**
 3. Consider use of oxytetracycline or penicillin.

C. *Equine antitoxin* is to be used only if human tetanus immune globulin is not available within 24 hours and only if the possibility of tetanus outweighs the danger of reaction to equine tetanus antitoxin. First, question patient and test for sensitivity.

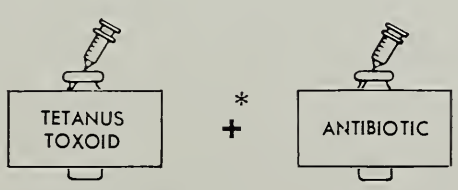


*Use different syringes, needles, and sites of injection.
**In severe, neglected or old wounds, 500 units of human tetanus immune globulin are advisable.

If patient is not sensitive to equine tetanus antitoxin, give at least 3,000 units.



If patient is sensitive to equine tetanus antitoxin by history or test, give penicillin or oxytetracycline, not antitoxin. Danger of anaphylaxis probably outweighs danger of tetanus. Do not attempt desensitization.



Source: Bulletin of the American College of Surgeons, Sept.-Oct. 1967. Reprinted with permission.

anus immunization? What percentage of patients know the difference between tetanus antitoxin or the "lock-jaw shot" and actively immunizing tetanus toxoid? A program of this sort successfully immunized over 60 per cent of the population of the state of Nebraska. A fund of over $6,000 for advertising media alone was provided by life insurance underwriters in the state.[4]

With this background, we can now review the current status of prophylaxis against tetanus in wound management, as recommended by the Committee on Trauma of the American College of Surgeons, with general principles and specific measures summarized on adjacent pages.

Basic active immunization should be carried out on all patients, with the usual initial injections four to six weeks apart, and the third of the series in six months to one year. So-called fluid toxoid was once believed to be superior to precipitated toxoid as a booster, because it produced a more rapid and higher response in the immunized individual. Actually, recent studies have concluded that the response is just as rapid, and, that the titre after eight weeks is higher with precipitated toxoid. For initial immunization, the precipitated toxoid is superior for its requires one less injection.

PREVIOUS TOXOID IMMUNIZATION

A person who has once had basic immunization with toxoid may have an adequate level of protection recalled by a booster dose no matter how many years have elapsed since the basic series or the latest booster dose. The recommended interval between booster injections, in the absence of injury, has gradually been lengthened to 10 years.

Significant reactions to tetanus toxoid continue to be rare. There are a few individuals with a true allergic sensitivity to the toxoid protein itself. True anaphylactic reactions are extremely rate.

In the event of injury, regardless of the immunization status of the patient, meticulous surgical care, including the removal of all devitalized tissue and foreign bodies, should be done as quickly as possible. If he has had previous adequate active immunization, only a 0.5 cc. booster dose is required. At the 1966 International Conference on Tetanus, there was much debate about the interval of time between the routine dose and the time of injury. The final statement in the guidelines that were adopted recommended a booster unless one had been given in the past year. Severely contaminated or deep wounds might warrant a booster in less than a year. The College of Surgeons has adopted the policy that the great majority of minor wounds will require only the 0.5 cc. booster of toxoid; however, in those cases that have an overwhelming possibility of tetanus contamination, 250 units of human tetanus immune globulin and antibiotics should be used.

CLEAN MINOR WOUNDS

For clean minor wounds in which tetanus is unlikely, in individuals not previously immunized, routine wound care is carried out, and the advantage of giving the initial immunizing dose of toxoid should be taken. Obviously, active immunity will not be produced rapidly enough to protect the individual for that injury.

For all other wounds, in individuals not previously immunized, through separate sites of injection, the patient should receive (1) an initial immunizing dose of toxoid, (2) 250 units of human tetanus immune globulin, and (3) probably an antibiotic. While the antibiotic will have no effect against the toxin, it has been shown to be effective against the tetanus bacillus.

Equine or bovine antitoxin is to be used only if human tetanus immune globulin is not available within 24 hours and only if the possibility of tetanus outweighs the danger of reaction to heterologous antitoxin. The patient should be carefully questioned and tested for sensitivity.

Fatal anaphylactic shock and serum sickness are reported in from 5 to 15 per cent of patients who are given equine or bovine tetanus antitoxin, and the half-life of the medication cannot be predicted in any given individual. Five thousand known cases of tetanus have been reported to follow the administration of heterologous antisera.[1]

Human tetanus immune globulin is a solution of gamma globulin prepared from venous blood of human beings found to be hyperimmunized with tetanus toxoid.[8] Small doses are effective for passive immunization, there are no known contraindications to its use, skin tests are unnecessary, and the half-life in the human is about three weeks. It is now commercially available from four manufacturers in sufficient amounts, and very rarely should heterologous antisera be indicated again.

ANTITOXIN USE, ABUSE

The use and abuse of antitoxin cannot be stressed too much. The International Conference on Tetanus in 1966 went on record as stating that it is the final medico-legal right and prerogative of an attending physician to decide whether or not

a heterologous antiserum with its associated dangers should be used. The College of Surgeons Committee has gone further to suggest that not only is the doctor extremely liable when he gives equine antitoxin, he would have little defense should his patient have a serious reaction.

SUMMARY

1. Though the incidence of tetanus has progressively declined, over 200 cases occur throughout the nation each year. The decline has been a result of a widespread understanding of prophylaxis against the disease. Mississippi, Florida, and Louisiana continue to lead the nation in cases reported. Mississippi's cases average from 12 to 20 per year.

2. In spite of the overall decline in numbers of cases, there has been little change in the past one hundred years in the mortality rate of cases which do develop. Tetanus is still a killer, eliminating 66 per cent to 85 per cent of its victims.

3. Present principles of prophylaxis with universal use of tetanus toxoid immunization should make tetanus a disease of historical significance only.

4. Within the year, the Trauma Committee of the Mississippi Chapter of the American College of Surgeons would like to request your cooperation in embarking on a program for education and immunization of every citizen within our state.

★★★

514-A Woodrow Wilson (39216)

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THE 'OH' ZONE

The highway patrolman stopped the elderly lady who was doing 66 mph in a 40-mile an hour zone. Protesting, the senior driver said, "But I saw a sign that said 66."

"Madam," the officer explained courteously, "that was the highway route number, not the speed limit."

"Oh, my goodness, officer," she exclaimed, "you should have seen me on Highway 120!"

Radiologic Seminar LXXVII: Delayed Diaphragm Rupture

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Laurel, Mississippi

A SERIOUS, and not uncommon, sequelae of blunt abdominal trauma is delayed rupture of the diaphragm. From a few hours to several weeks after the initial trauma, necrosis of the original contused area or extension of a small tear occurs and the diaphragm ruptures and spills the adjacent abdominal contents into the chest. The liver tends to protect the right diaphragm, so 95 per cent of ruptures occur on the left. Frequently, other organs are injured with the rupture, including avulsion of the splenic pedicle and hemorrhage.

Clinically, the initial diaphragm injury frequently goes unnoticed or is obscured by the patient's other injuries. Later, however, when rupture occurs, the patient may become quite ill, depending upon the size of the hernia and the organs involved. Uncomplicated hernia has a good prognosis. Bilateral ones are rare and generally

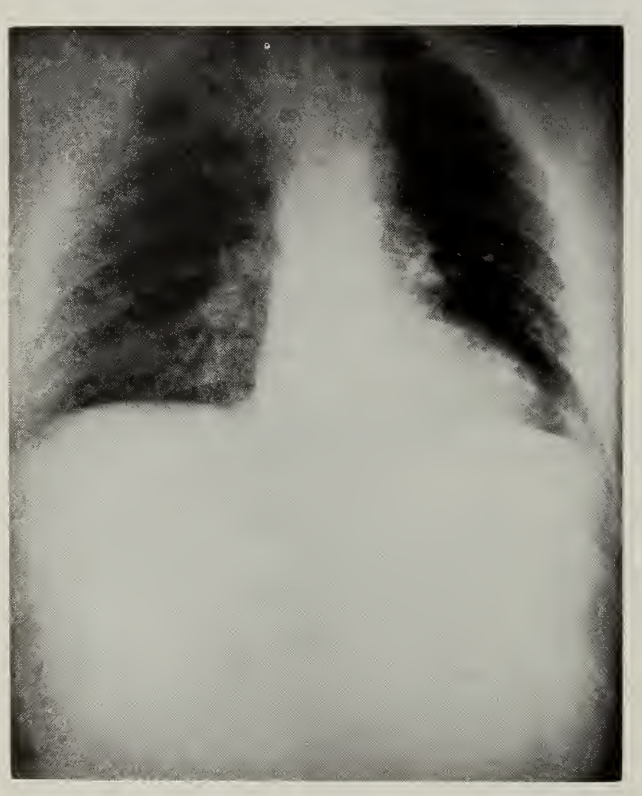


Figure 1A. G.D.G., age 68, was crushed by a tractor. The initial AP, supine, 52″, bucky chest film reveals the multiple right rib fractures plus a slight pneumothorax. Except for slight focal atelectasis, however, the left lung is clear.



Figure 1B. The patient developed left chest pain, dyspnea, and rapid pulse and this portable chest was made 14 hours after the previous one. The density in the left base (see arrows) represents a hernia of the proximal third of the stomach, causing some collapse of the left lower lobe, with considerable hemorrhage.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Jones County Community Hospital.



Figure 2A. Mrs. N.B., 48, sustained multiple contusions and lacerations in a car wreck with a fracture of the left arm and left leg. The initial AP, 52", bucky chest film shows a slight haziness adjacent to the left diaphragm considered to represent a contusion there. There were no specific symptoms related to this area and the patient obtained no further chest x-rays during the six days of hospitalization.

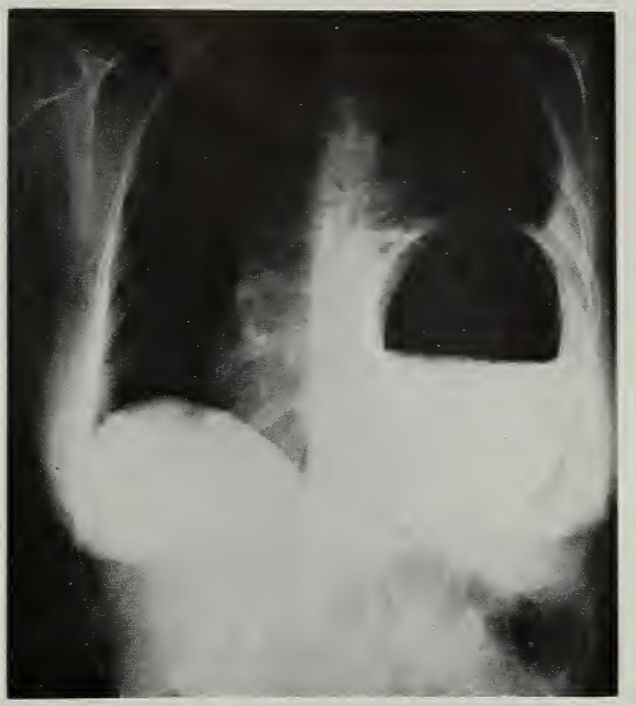


Figure 2B. Five weeks later, the patient experienced left chest pain, tachycardia, weakness, and epigastric distress and fullness. EPA view of the chest with barium in the stomach reveals the upper half of the stomach now in the chest cavity displacing the mediastinum to the right with blood in the left pleural space. At corrective surgery, the spleen was also found in the hernia but the splenic pedicle fortunately was not torn.

fatal. Large hernias produce severe respiratory embarrassment due to a combination of loss of use of the diaphragm, which is the major respiratory muscle, lung collapse and mediastinal displacement by the mass, hemorrhage and sometimes shock. Immediate surgery is required.

Sometimes, there is an asymptomatic interval after injury for six weeks or longer. Carter *et al.* have found that 90 per cent of strangulated diaphragmatic hernias were traumatic in origin and 85 per cent occurred within three years of injury. In a study of 500 patients who had surgical repair of hiatal hernia, Lortat-Jacob *et al.* found that 14 had a history of serious trauma. They believe that hiatal hernia can follow acute thoraco-abdominal injury.

The radiographic findings of traumatic diaphragm hernia have been presented in a previous radiologic seminar and will not be repeated here. The important point to be emphasized here, however, is that the initial radiograph after diaphragm injury may be normal or almost normal in appearance. After blunt abdominal trauma, therefore, the slightest asymmetry or diaphragm irregularity, pleural fluid, or basilar pulmonary contusion should be viewed with concern, diaphragm injury suspected, and the possibility of delayed rupture considered. Further investigation is indicated with serial x-ray studies, lateral decubitus views, barium contrast studies, and fluoroscopy for restricted diaphragm movement. Pneumoperitoneography using 50 cc. of 100 per cent carbon dioxide may be used safely to outline the under surface of the diaphragm when its position is in doubt. An actual rent in the diaphragm will cause a temporary small pneumothorax.

Two cases of diaphragmatic injury are presented here with rupture following at 14 hours and five week respectively. ★★★

Jones County Community Hospital (39440)

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Profile of Attainment—Measure of Need, Part III

WILLIAM O. BARNETT, M.D.
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POSTGRADUATE or continuing medical education programs in Mississippi are presently minimal. Only one source, the University Medical Center, offers regularly scheduled seminars, symposia, and circuit courses. The annual session of the Mississippi State Medical Association is, by far, the largest such assembly with a five year mean attendance exceeding 1,000 among whom about 600 are physicians. The second such largest annual assembly is sponsored by the Mississippi Academy of General Practice which is understood to have experienced a mean annual registration of 200 to 300 among whom at least half are physicians.

The 20-odd specialty societies are relatively small by comparison, and at annual meetings, an attendance of 75 would be considered excellent for the larger groups. The numerically smaller specialties are more often than not about 20 in number, but this is no indictment, since such an attendance may represent 50 per cent of their total professional population.

During the 1967-68 academic year, nationally, 387 sources sponsored 1,830 programs of continuing postgraduate medical education for practicing physicians, according to the AMA Council on Medical Education. Among these were 71 medical schools and university centers, 201 nongovernment hospitals, 35 county and state medical societies and postgraduate medical assemblies, such as those in New Orleans and Memphis (the Mid-South), 27 academies of medicine and the American Academy of General Practice, seven by voluntary health agencies, and 46 by miscellaneous agencies and organizations, including postgraduate medical schools, and city, county, state and federal agencies.

It becomes immediately apparent, in the light of these facts, that in Mississippi, only slightly more than 1 per cent of all formal postgraduate or continuing medical education is being offered.

In the third part of the series on the study of postgraduate medical education in Mississippi, a critical examination of the state's postgraduate medical capabilities and opportunities is made. This portion of the study considers not only continuing education for practicing physicians but formal specialty training capacities as well. Detailed comparison with similar opportunities in the neighboring states of Alabama, Arkansas, Louisiana, and Tennessee is made.

A further comparison with comparably populated states, Arizona, Colorado, Kansas, and Oregon, each smaller than Mississippi, makes the distinctions drawn in the study conclusions even sharper.

Seventy per cent of the total national field comprise seven subject headings: Internal medicine with 338, always the leader in this endeavor, psychiatry with 333, general practice with 214, pathology with 146, surgery with 108, obstetrics and gynecology with 77, and ophthalmology with 76, a total of 1,292 of the 1,830 recognized continuing education courses.

According to the AMA council, general practitioners constitute 60 per cent of the enrollment in 1,205 of the 1,830 courses, and this demonstrates the desire of this discipline for quality continuing education. The AMA classifies all such courses offered as continuous, intermittent, post-

Chairman, Council on Medical Education and member, Board of Trustees, Mississippi State Medical Association.

Adapted from the study report approved by the House of Delegates, 100th Annual Session, May 13-16, 1968.

graduate traineeship, home study, circuit, TV-radio, and other or not specified.

Since Mississippi, to some extent, must always compete with her neighbors, Alabama, Arkansas, Louisiana, and Tennessee, it is interesting to observe that while Mississippi has one source of formal continuing, postgraduate medical education for practicing physicians, Alabama has three; Arkansas, two; Louisiana, 15; and Tennessee, four. The clearly stated response in the survey of Mississippi physicians is an emphatic index to their reaction to this lack of postgraduate training opportunity. A previously completed authoritative study done by the respected research firm of Booz, Allen, and Hamilton has already inferred that two of the four neighboring states, Arkansas and Alabama, depend on external training sources for physicians. Obviously, Mississippi is in the same situation, and as examination of undergraduate and postgraduate capabilities will show, only Louisiana and Tennessee among the five states are measuring up to medical training needs.

There is a positive as well as a negative aspect to the postgraduate training future of the medical profession in Mississippi. This is demonstrated in the Alabama study in which a comparison of the six southeastern states is made.

19TH NATIONAL RANK

Mississippi ranks 19th nationally in first year medical students per 100,000 bachelor degrees awarded in 1966, the most recent year for which these data are available. Florida, Georgia, Louisiana, and Tennessee lead the state, but each is unusually high in this achievement in medical education. Statistically, this is the comparison:

National Rank	*State*	*First Year Medical Students/100,000*
7th	Florida	26
8th	Georgia	25
11th	Louisiana	22
12th	Tennessee	21
19th	Mississippi	19
31st	Alabama	16

With the University of Mississippi School of Medicine graduating progressively larger classes each year, the challenge and need to intensify continuing education for physicians, as well as increasing formal postgraduate opportunities, is underscored. The ironic alternative seems to be that Mississippi would merely be expending effort and substance to train physicians for other states.

Although the four year medical school is young by comparison with other institutions, its successes in undergraduate medical education are demonstrated by the growing rate of entering first year medical students. Mississippi ranks 21st nationally in entering first year medical students per 100,000 population.

Again, comparing the state with its five southeastern neighbors, the statistics are:

National Rank	*State*	*First Year Medical Students/100,000*
15th	Tennessee	4.75
18th	Louisiana	4.60
21st	Mississippi	4.33
37th	Florida	3.60
44th	Alabama	3.00

That the University of Tennessee has the largest medical school in the nation in terms of enrollment is obviously a significant factor in its high national rank.

Mississippi lags behind its adjacent neighboring states in formal medical postgraduate opportunity, as demonstrated by Table 1. There is only one institution in the state offering continuing education for physicians, the University Medical Center. By contrast, Alabama has three; Arkansas, two; Louisiana, 15; and Tennessee, four.

Three hospitals in Mississippi are accredited for internship programs with 53 positions. Alabama has eight hospitals with 128 positions; Arkansas, three with 60 positions; Louisiana, nine with 247 positions; and Tennessee, 12 with 265 positions.

The posture of the state in formal residency programs for the specialties is less than that of its neighbors. Seven sources of formal residency training in Mississippi are listed by the AMA Council on Medical Education with 22 approved programs:

Source	*AMA-Approved Residency Programs*
University Medical Center	18
USAF Hospital, Keesler Air Force Base, Biloxi	2
Veterans Administration Center, Jackson	13
Veterans Administration, Gulfport Branch	1
State Board of Health, sponsorship	2
Mississippi State Sanatorium	1
Mississippi State Hospital, Whitfield	1

Because of interinstitutional affiliations and the sponsorship aspect of the State Board of Health, there are actually 22 AMA-approved residency programs with 134 positions.

In contrast, there are 11 sources with 47 programs and 325 positions in Alabama. Arkansas has six sources, 24 programs, and 176 positions;

TABLE 1

MID-SOUTH FORMAL POSTGRADUATE OPPORTUNITIES

Item for Comparison	*Mississippi*	*Alabama*	*Arkansas*	*Louisiana*	*Tennessee*
Institutions With PG Programs	1	3	2	15	4
Hospitals With Internships	3	8	3	9	12
Total Internships	53	128	60	247	265
Institutions With Approved Residencies	7	11	6	15	24
Total Residency Programs	22	47	24	87	95
Resident Positions	134	325	176	739	659

Louisiana, 15 sources, 87 programs, and 739 positions; and Tennessee, 24 sources, 95 programs, and 659 positions.

It is clear that Mississippi cannot meet its own need for training in the specialties.

As with neighboring adjacent states, Mississippi generally lags comparably populated states in formal postgraduate medical education opportunity. Table 2 presents such a comparison where the state is measured against Arizona, Colorado, Kansas, and Oregon. Except for Arizona, with which there is slightly less than equal comparison, each state has a population approximating Mississippi's 2,281,000, the adjusted total through 1966.

Except for Arizona, physicians are more numerous than in Mississippi, especially in the nonsurgical specialties, but only Kansas has a significantly larger number of general practitioners. Again with the exception of Arizona, there are three to six times the institutions offering continuing education courses for physicians, and there are correspondingly larger internship and residency programs and positions. To round out the medical picture, the number of hospitals and hospital beds in each state are shown. These are general medical and surgical institutions, and federal, mental, tuberculosis, and other specialized institutions are omitted from these totals.

It may be contended that the comparison is not altogether pertinent because of economic differences among the states. It is also recognized that each state compared with Mississippi has much larger metropolitan areas, too. But the realism of the comparison is found in the demand for medical services which is measured by population, and the need may be greater in areas of lower economic wealth.

Still another pertinent aspect is that the postgraduate needs of the profession must be met adequately, and the comparison demonstrates that Mississippi lags comparably populated states in this area.

The University Medical Center at Jackson has performed a valuable service in postgraduate medical education by offering a variety of semi-

TABLE 2

POSTGRADUATE PROGRAMS IN COMPARABLY POPULATED STATES

Item for Comparison	*Mississippi*	*Arizona*	*Colorado*	*Kansas*	*Oregon*
Population	2,281,000	1,640,000	2,013,000	2,270,000	1,922,000
Physicians	1,776	1,731	2,883	2,216	2,368
GP	697	504	667	804	688
Nonsurgical	623	714	1,350	865	1,055
Surgical	456	513	866	547	625
Institutions With PG Programs	1	1	6	3	3
Hospitals With Internships	3	6	12	5	7
Total Internships	53	78	192	80	98
AMA-approved Residencies	7	9	16	10	8
Total Residency Programs	22	23	72	38	38
Resident Positions	134	133	475	435	295
Total Hospitals*	116	56	68	134	74
Total Hospital Beds	7,465	5,343	8,314	9,763	9,776

* General medical and surgical only. Excludes federal, mental, tuberculosis, chronic disease. children's, and those not recognized by AHA and AMA as hospitals.

nars. Table 3 examines these presentations for the years 1966 and 1967.

In 1966, UMC conducted 11 seminars, among which were 10 single subject occasions and one multiple subject offering. The highest attendance was 43, the low was nine, and the mean attendance was 17. In 1967, there were 14 seminars where the high attendance was 54, the low two, and the mean 30. Beginning in January 1967, the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION initiated a new feature department, "Postgraduate Calendar." Each month, announcements and programs of seminars have been published. The UMC Committee on Postgraduate Medical Education believes that to some extent, this new JOURNAL feature has assisted in improving attendance.

UMC CIRCUIT COURSES

A second major postgraduate program of the University Medical Center is that of circuit courses. Table 4 analyzes these opportunities for the years 1966 and 1967.

In 1966, 11 out of 18 courses were conducted in the southern area of the state. It should be noted that location of the courses is in response to the desires of the local physicians, with appropriate consideration given by UMC to the concentration of physicians in various areas of the state and to the potential benefits which might be realized in the selection of sites of courses. The 11 southern courses had a total attendance of 284 physicians with a high of 36, a low of 14, and a mean of 26.

Of the four circuit courses conducted in the northern area of the state, also during 1966, a total of 59 physicians were in attendance with a single high of 18, a low of 12, and a mean of 15. The three mid-state courses were attended by 48 physicians with a high of 20, a low of 10, and a mean of 16.

TABLE 3

UMC POSTGRADUATE MEDICAL SEMINARS

Seminars	*1966*	*1967*
Total Seminars Conducted	11	14
Single Subject Seminars	10	13
Highest Attendance	43	54
Lowest Attendance	9	2
Mean Attendance	17	30
Multiple Subject Seminars	1	1
Highest Attendance	36	26
Lowest Attendance	—	—
Mean Attendance	—	—

In 1967, the medical center presented 16 circuit courses with seven in the north, two in the mid-state area, and seven in the south. Total attendance was 345, a decrease of 11.51 per cent from the previous year.

TABLE 4

UMC CIRCUIT COURSES

Circuit Course	*1966*	*1967*
Total Courses	18	16
North	4	7
Mid-State	3	2
South	11	7
Total Attendance	391	345
North	59	125
Mid-State	48	68
South	284	152
Attendance Characteristics		
North		
High	18	23
Low	12	14
Mean	15	18
Mid-State		
High	20	39
Low	10	29
Mean	16	34
South		
High	36	31
Low	14	16
Mean	26	22

In the north, 125 physicians attended, with a high of 23, a low of 14, and a mean attendance of 18. In the mid-state area, 68 physicians attended, with a high of 39, a low of 29, and a mean of 34. In the diminished southern circuits, 152 were in attendance with a high of 31, a low of 16, and a mean of 22.

SPECIALTY SOCIETIES

The various specialty societies conduct meetings designed to meet the needs of their respective memberships on varying bases. Some meet annually, others on a more frequent basis. There are about 20 such groups in the state, but the extent of their formal continuing education activities is such that an analysis would add little to the study beyond their individual responses to the survey.

★★★

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This study was assisted in part by the Regional Medical Program of the University Medical Center, Jackson.

SOCIOECONOMICS

Professional Compensation by Usual and Customary Fee

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Medical care financing sources, voluntary health insurance, prepayment plans, and publicly-supported programs, are moving toward professional compensation under the concept of usual and customary fees. This study describes the methodology involved, looks at the innovation of the fee profile, and examines the evolution of compensation mechanisms.

As a background, trends in costs of the several medical care components are noted, and the growing demand for medical services is studied as an influence on costs.

THE ALMOST MAGIC phrase, "usual and customary fee," conjures up varied visions among physicians, patients, legally responsible medical care financing organizations, and agencies of government. It is a relatively new expression, considering that voluntary health insurance and prepayment plans are more than a generation of age. It is generally an insufficiently defined designation, often meaning different things to different individuals.

But this much seems to be agreed upon: Carried out in a candid environment of mutuality, compensation for professional services by the usual and customary fee concept more nearly approaches a satisfactory method of purchasing medical care than any method previously employed.

This brief narrative study about usual and customary fee reimbursement has as its purpose the communication of information. Despite quotation of friend and adversary, real or fancied, not a single word of advocacy is intentionally included in the paper. The making of policy in the Mississippi State Medical Association is a prerogative reserved to the appropriately designated constitutional bodies and assemblies. Advocacy of policy is properly reserved to the editorial pages of the JOURNAL. So, as with other papers, the present purpose is instructive.

Millions of words have been written in countless papers, articles, studies, and books about the cost of medical care. It is a complex structure not easily dissected into definitive components before which a dollar mark may simply be placed. These costs are influenced by a variety of factors not always related to the acts of purchase and providing the care, and frequently, costs are affected by influences beyond the control of the patient, physician, and hospital.

While this study is no attempt to treat comprehensively the costs of medical care in the United States, some discussion in this area is essential to consideration of the costs of the professional care component and its financing. In 1960, Americans spent just under $20 billion for their health services. In 1966, the most recent year for which reliable data are available, the expenditure was just under $32 billion.

This combined expenditure represents about 6 per cent of our disposable personal income of $509 billion that year. DPI is an engaging phrase used by the economists to describe what we have left after the tax bite, which is substantial, because the nation is generating about $850 billion in its annual gross national product of all goods and services.

The largest portion of the total health care bill went to hospitals, $9.6 billion. Physicians' services were $8.3 billion, while the outlay for drugs

Executive Secretary, Mississippi State Medical Association.

was $5.1 billion. Dental services cost $3 billion, and the nation's expenditures for appliances, other professional services, and health insurance were respectively $1.6, $1.5, $2.1 billion. As has been the pronounced trend and pattern for a decade, the hospital's share of the medical care dollar is growing, while all other shares have diminished.

This does not infer, of course, that levels of compensation or exchange per unit of service have concomitantly diminished. The distribution of the health care dollar is relatively stated in the respective component expenditures.

Over the long pull, the costs of health care services—as is true of any voluntary purchase—are structured on rational bases relevant to the times. And as is also true of any free market, there are occasional aberrations which are generally notable because of infrequent occurrence.

The American Medical Association believes that the two pressing problems confronting medicine today are the costs of care and the health manpower problem. That there is an increased demand for medical services over the past decade is undeniable:

REASONS FOR DEMAND

—Simply stated, there are more Americans than ever before, 200 million, in fact, so there are more consumers of medical care.

—The level of health education among all segments of our population has increased remarkably and dramatically, and Americans are more health-conscious than at any time in the nation's history. Since 1941, more than 25 million young men and women have served in the armed forces where regular, quality health care was an educational experience. The mass communications media—newspapers, television and radio, and popular magazines—are replete with popular health and medical presentations.

—Medicine has much more to offer with each new care capability and the ever-growing fund of scientific knowledge.

—And the availability of medical care in the United States is second to no nation of the world, what with about 170 million citizens covered in some degree by some form of health insurance or prepayment plan. This does not take into account the myriad of government care programs ranging from services for veterans to Medicare for those over age 65.

So, despite the amazing growth of our medical schools, from 77 in 1948 to 105 by 1975, and the growing numbers of graduates each year, from 6,000 in 1948 to an estimated 10,500 annually by 1975, we are hard pressed to keep pace with the strides of science, the ease of care purchase, and the new economics of care which a generation ago meant virtually nothing.

PERSONNEL SHORTAGES

Skilled personnel are the crucial quantities in the success or failure of our hospitals. In 1966, there were about 150 such full-time employees for each 100 patients, an increase in staff of 107 per cent in 20 years. But this is an inclusive mean, because in 1966, there were only 47 employees per 100 patients in nonfederal psychiatric hospitals. In acute, short-term hospitals, there were as many as 296 employees per 100 patients.

Shortages of trained allied professional personnel aggravate hospital costs as the institutions compete for graduate professional nurses, licensed practical nurses, medical technologists, x-ray technicians, aides, and others. The recently enacted federal minimum wage laws have further compounded hospital cost problems, logically and consequently showing up in billings to patients.

In any free market, there must be a reliable yardstick for measuring prices. It is also important to make a distinction between "price" and "cost," because they are different. A price, as the student of elementary economics knows, is an offering or an initial barter on the part of the seller, while cost bears full relationship to the expense incurred in providing a given good or service.

American business, industry, and government use a yardstick called the Consumer Price Index. It is compiled by the Bureau of Labor Statistics of the U.S. Department of Labor, and in the context which it is presented, the CPI is the best measure we have. It is the basis for the familiar "cost of living index" which we hear mentioned frequently in the news.

CONSUMER PRICE INDEX

The CPI is a relatively simple method of pricing measurement: A given period, currently 1957-1959, is taken as the base. All prices are then said to be at an index of 100. Thus, if a pair of shoelaces were priced at 10 cents in 1959, and if the same shoelaces were priced at 15 cents yesterday, we say that this item is 150 on the Consumer Price Index, because it has risen 50 per cent in price. The CPI reflects all expenditures which we make, including those for health care services.

Between 1956 and 1966, the decade which includes the current CPI baseline, the overall prices we paid for all goods and services rose 19 per cent. In the same period, the index on all medical care rose 42 per cent. The zooming costs of hospital care are largely responsible for these increases, because hospital prices have increased between 7 and 16 per cent per year during the decade.

In 1966, hospital costs increased 16.5 per cent, and physicians' fees went up 7.8 per cent. This factual statement is *not* intended to reflect adversely upon either increase. It is, however, to point out that the sharpness of the price rises can and does exert a severe impact upon actuarial bases in voluntary health insurance and prepayment plans, just as it can with publicly-supported programs of care, say Title XIX, for example, where fixed appropriations must somehow be adjusted to upward change.

It is against this background that the methods employed in compensating physicians for professional services rendered are examined.

Generally speaking, there are four ways in which to secure medical care: To have it given gratuitously by the provider, to purchase it for cash out-of-pocket, to insure against its need at some future time by prepayment or insurance, or to have society purchase it in the recipient's behalf.

AINSWORTH'S VIEWS

In his address to the 100th Annual Session of the Mississippi State Medical Association, the then-president, Dr. Temple Ainsworth of Jackson, said that for a variety of reasons, not necessarily centered on the physician, the aspect of having care given is impractical. He continued by pointing out:

"For the nation to purchase all of its health care out-of-pocket is also unrealistic, especially when the need for purchase may be a single event at a single point in time."

Dr. Ainsworth said that there remain the two methods of securing care, for all intent and purpose, that of contracting to insure or prepay it and that of having government make the purchase. He emphasized that "the soundness, equity, and propriety of any method of medical care financing must be concerns of physicians as well as others, because physicians share in the responsibility for the success of methods which measure up to the needs of society."

Perhaps Dr. Ainsworth's strongest point is this: "And since a physician—and only a physician—properly can and ethically should place a price on his services, he has a further responsibility as to adequacy and proper use of financing devices."

In response to a Mississippi resolution, the American Medical Association redefined its goals. purposes, and responsibilities in 1967 by formal adoption of an 11-point statement. One point is pertinent in the context of this discussion. Each of the 11 points is prefaced by this declaration:

AMA GOALS

"It is the responsibility of the American Medical Association, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people. Its continuing purposes are to meet this responsibility through the following means:

"6. By developing techniques and practices that will moderate the costs of good medical and health care."

It is, therefore, a matter of deed and record that the medical profession has a concern for the cost of care—good medical care—because care based on cost alone is not what physicians are talking about. There are, regrettably, some apart from the profession who seem as if cost were the only consideration in provision of medical care.

On two occasions during 1968, the President of the United States made less-than-complimentary reference to health care costs in messages to the Congress. Last year, the Department of Health, Education, and Welfare sponsored separate conferences on health care costs and the promotion of group practice (a term more familiar to the medical community as "closed panel" practice).

On the other side of the coin, medical organization has expressed the desire to be conscious of care costs but to assure care quality. Dr. Ainsworth made this clear in recommending that the state medical association extend the concept of a physician's dealing with his peers in establishing fee review committees. The House of Delegates adopted the recommendation.

METHODOLOGY EVOLUTION

Apart from the purchase for cash of professional services, there has been a progressive—in the sense of developmental refinement—evolution in the compensation of physicians by insurance, prepayment, and government sources.

First, there was the principle of simple indem-

nity. It has been argued that indemnity is the least useful form of health care benefit, because it is inherently limited in value. As such, the argument continues, it offers little assurance that the patient will be spared the burden of heavy expense at the time he is least able to afford to bear it. Moreover, the physician, having no claim upon the benefit after rendering his professional services, must be prepared to take his losses in any case where the patient cannot or will not pay.

Second came the fixed fee schedule, closely related to the indemnity concept, but better oriented to the service rendered. As suggested in its description as "fixed," it was generally inflexible.

Full service, a third development, was hailed in its day as an ultimate refinement, because it was the first paid-in-full care concept. Tied to an income ceiling, full service had the support of those who argued that it provided all the care a patient needed, despite limited resources. Since the eligibility of the patient to purchase full service coverage was contingent upon his earning no more than the stated ceiling, it was contended that he could not have paid out-of-pocket even as much as the limited benefit. The physician was assured of his fee, although usually at a modest level.

The Mississippi State Medical Association never approved the full service concept, and it has fallen largely into disuse because of pressures by prepayment plans to raise income ceiling and thus barter away professional services at depressed scales.

Fourth, the negotiated fee came into being about the mid-1950's, and it represented a significant step forward in being related—at least at the time of negotiation—to the going price for professional services. It was popular, and it became the bulwark of the original military Medicare, the former Dependents' Medical Care Act of 1956, now the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The greatest difficulty with the concept of negotiated fees was its tendency to remain static and resistant to upward revision.

CALIFORNIA RVI

In 1954, the California Medical Association, always a leader in medical socioeconomics research and development, published its first Relative Value Index. Accepted almost at once by a majority of medical organizations, the RVI provided two things previously absent from compensation mechanisms:

—The physician made his own decision as to his fee, selecting his conversion coefficient while maintaining relativity among his various charges.

—The entire concept of the RVI was practice-related and not primarily oriented to nonmedical considerations in the provision and purchase of medical care.

The Mississippi State Medical Association developed a RVI during 1960-1961, but it was disapproved in an unprecedented membership referendum. Within six years, the association's House of Delegates adopted the concept. In the meanwhile, most state medical associations adopted a RVI.

USUAL AND CUSTOMARY

The sixth and most realistic development is professional compensation by usual and customary fee. It is a range within which a majority of physicians in a given geographic area make charges, and it is distinguished by being related to practice rather than to formal agreement. The concept presupposes that the fee charged covers the professional services rendered, so to that extent, it embodies the best in the paid-in-full concept.

With this liberalization from the fixed or maximum fee concept there goes responsibility, because at some point, there must be a reasonable extreme to any fee range. Dr. Ainsworth, in his address, had this to say:

"But usual and customary does not mean charging what the traffic will bear nor is it a license to inflate fees beyond reason. The local medical community, meaning the component medical society, carries great responsibility in making the concept work."

At the 20th Clinical Convention in 1966, the AMA House of Delegates adopted definitions of "usual and customary" and "prevailing" charges, together with a definition of "reasonable" charges which is related to the two other definitions:

Usual or Customary Charge: A usual or customary charge is defined as that amount which the individual physician commonly establishes as fair recompense for a specific service.

Prevailing Charges: Prevailing charges relate to the full range of usual or customary charges made by physicians of similar ability and experience for the same service within the same geographic area.

Reasonable Charge: A reasonable charge is defined as a charge which meets the criteria of "usual or customary" charges or is justified by the special circumstances of the particular case in question. The final determination of the reasonable charge in any questioned case should be

made by a duly constituted review committee established by the medical society having jurisdiction.

It is at this juncture that the device of fee review by a committee of the component medical society enters the picture, and this was Dr. Ainsworth's recommendation which the House of Delegates adopted. In making this recommendation, Dr. Ainsworth pointed out that peer review was nothing new in medical organization. He reminded the association that grievance committees, often concerned with fees, had existed for years.

He recommended, in consonance with the AMA guides for fee review committees, that this service be available to "all elements concerned with the financing of medical care." This includes matters submitted by patients, physicians, hospitals, prepayment and voluntary health insurance organizations, employers, and any voluntary health and governmental agencies.

The fee review committee is not punitive, and it may never exercise a disciplinary function. But even more than that, it also represents the proper interests of the physician in assuring just and adequate professional compensation, as it carries out the wishes of the majority in medicine as to occasional excessive charges.

There are any number of methods of establishing a compensation system based upon usual and customary fees. It is not unexpected to hear this question: Why not pay whatever the physician charges?

Rather than being based upon usual and customary fees, such a system would be fiscally unsound where utilized by an insurance company, prepayment plan, or publicly-supported care program. This is not, however, to deny the prerogative of the individual practitioner to place a value upon his own services, and indeed, this is as it should and must be. It is, according to practice and usage, a means of compensating at least 90 per cent of physicians in a given area at the going rate of charges.

WIDE USE OF CONCEPT

More than half of the Blue Shield plans in the United States have adopted the usual and customary concept in some degree. Most Title XIX programs are under this concept. The biggest and best known usual and customary fee program is Part 1-B of Medicare, and the most recent nation-wide addition is the CHAMPUS program. AMA and nearly all state medical associations are on record firmly supporting professional compensation by medical care financing sources under the concept of the usual and customary fee.

For over-65 Medicare, the Social Security Administration defines the concept as "those charges which fall within the range of charges most frequently and widely used in a locality for particular medical procedures or services. The top of the range establishes . . . an overall limitation on the charges which a carrier will accept as reasonable for a given medical procedure or service."

MEDICARE REGULATIONS

The SSA regulations go on to define these charges as being "derived from the overall pattern existing within a locality. For example, in a given locality, the carrier may find that the charges most frequently and widely used by physicians for a particular medical procedure range from $150 to $175. If, in another locality, the carrier finds that the prevailing charges are different for the same procedure, then a different range of charges would be applied in making reasonable determinations for that locality."

This introduces the arithmetic of statistics into the picture with three familiar and one less familiar terms: The mean, median, mode, and the standard deviation.

Most popularly known as the "average," the *mean* is an arithmetic midpoint among unequal quantities derived by dividing the sum of the quantities by the number of the quantities. It is useful when the data in a series fall closely together, but when they are spread over a span of values so as to be substantially unequal, the mean distorts the presentation.

The *median* is simply that point in a statistical series where half of the data are to one side and half are to the other. To the extent that the median divides the data into useful groups, it is helpful.

The *mode*—literally "the fashion" from the French *la mode*—simply is that quantity which occurs most often in a statistical series. It is highly useful in working with professional fees, because it quickly identifies the "most usual" or "going rate."

Here is an overly-simplified example:

In a given community, 10 physicians make charges for initial hospital visit without complicated diagnostic problems as follows: One charges $5; another, $7; a third, $8; four charge $10; two, $12; and one, $16. The series of these fees appears thus:

$5, $7, $8, $10, $10, $10, $10, $12, $12, $16

It is readily seen that the *mean* is $10, the sum of the series being $100 divided by the number of quantities, 10. The *median* is at $10, this being the point at which five members of the series are to either side. Since $10 is the most frequently occurring quantity in the series, it is also the *mode*.

When a statistical series is plotted on the classic x (horizontal) and y (vertical) axes, it typically will appear as a bell-shaped curve. If there are sufficient quantities in the series and if there is sufficient distribution of quantity values, the bell-shaped curve will be symmetrical. This is a Gaussian curve which illustrates *percentiles* and to which the device of the *standard deviation* is applicable.

This is a mathematical expression to describe measurement of the extremes of the Gaussian curve, say to isolate 5 per cent from either extreme, thereby leaving 90 per cent of the original distribution. The highest values then in the plot become the top of the 90 percentile. As a rule, the sum of the mean and one standard deviation will measure 90 per cent. This is the basis for the Social Security Administration having included this measure of usual and customary fees in its Medicare regulations:

STANDARD DEVIATION

"An acceptable method for the carrier to objectively determine the point at which such limitation (top of the fee range) is established would be to use the mean of the customary charges of physicians in the locality for a given medical procedure or service plus one standard deviation above the mean rounded to the nearest dollar."

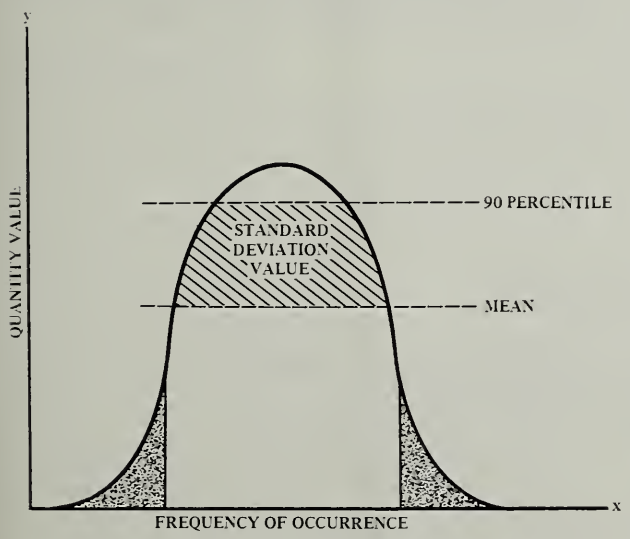


Figure 1. Graphic description of a Gaussian distribution, showing the mean for all values plotted. Addition of one standard deviation to the mean usually represents a value in the 90 percentile.

To illustrate, we must first know that the standard deviation, in precise mathematical terms, is the square root of the arithmetic mean of the squares of the deviation of the various items from the arithmetic mean of the whole.

SD FORMULA

This academic mouthful really says that where N represents the occurrence of an item (times a fee is charged) and D represents the difference, either plus or minus, from the mean of all such fees in the series, the computation goes like this:

The mean in our hospital visit series is $10.

The deviations from the mean for the various members of the series are these:

$5, represented as N_1, deviates *minus* $5, shown as D_1.

$7, represented as N_2, deviates *minus* $3, shown as D_2.

$8, represented as N_3, deviates *minus* $2, shown as D_3.

$10, represented as N_4, deviates *zero,* shown as D_4.

$12, represented as N_5, deviates *plus* $2, shown as D_5.

$16, represented as N_6, deviates *plus* $6, shown as D_6.

Our formula for determining the standard deviation is:

$$1\ SD = \sqrt{\frac{N_1(D_1)^2+N_2(D_2)^2+N_3(D_3)^2+N_4(D_4)^2+N_5(D_5)^2+N_6(D_6)^2}{N_1+N_2+N_3+N_4+N_5+N_6}}$$

Arithmetically, this results in a value of $2.864 which is one standard deviation. Rounded to the nearest dollar, as stated in the SSA regulation, it is $3. Therefore, the mean of $10 in our hospital visit fee series plus the $3 standard deviation would peg the top of the range, the 90 percentile, at $13, the maximum amount a Part 1-B carrier could recognize under ordinary circumstances.

But over-65 Medicare, as do most other usual and customary programs, seeks to compensate a physician fairly for professional services actually rendered. Where extra or additional services must be rendered because of a difficult condition or complication, then additional compensation will usually be paid.

Finally, there is the device of the *fee profile,* sometimes a misunderstood measurement of usual and customary fee by medical care financing sources. A fee profile is nothing more than a

series of fees actually charged during a stated period of time in a given medical community or locality for the same service. Our initial hospital visit series was, in fact, a profile of charges for this service.

When this method first came into use, some Blue Shield plans tied the profile to the individual physician, but a different application is now often made of it. The profile is tied only to the medical locality and procedure and not to any physician. A fee profile cannot properly be hypotheticated or projected. It must be *strictly objective,* and every member of a profile series must have been an actual charge for the stated service by a physician in the particular locality.

Does a profile irrevocably fix or freeze professional fees?

The answer is emphatically in the negative, because it is a practice-related yardstick, capable of rising or falling with general economic levels. To be sure, a sharp increase which is geographically isolated is almost certain to attract the attention of medical fee review committees. But a general trend with reasonable geographic spread is a signal to move the professional compensation index upward.

SUMMARY

In summary, compensation of physicians for professional services by usual and customary fee means that doctors themselves are properly placing a value on their respective services under an established system of peer review. It is a concept under which an actuarially-based financing source can work effectively, as can a publicly-supported source with periodic appropriations. It is intended to meet the charges of at least 90 per cent of the practicing community, but more often than not, it has been shown to meet a broader spectrum.

POSTSCRIPT

It is an appropriate postscript to note that no care financing mechanism can possibly meet the desires of all who provide medical care. To be sure, individual professional prerogative should be preserved and the private care delivery system upheld. It would be myopic to believe that the usual and customary concept is the ultimate refinement in health insurance, prepayment, and government programs. But is here today, and it demands the understanding of all.

735 Riverside Drive (39216)

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The President Speaking

'The Chasm'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

THE GROWING CHASM between physicians and hospitals is a matter of deep concern not merely to the medical profession and hospital industry but to every American. Polarization of certain attitudes by hospital administrators particularly widens this regrettable gap. Where this occurs, it shows up in the efficiency of the health care team and in the quality of care which is rendered.

Most physicians earnestly desire to spend all their time in the care of the sick. This is the all of why we went through years of rigorous training. To this end we have tried to turn over the training and governing of nurses to others and the running of hospitals to others. But, we are finding ourselves caught in a trap in which the physician, the only individual capable of assuming responsibility for the care of the patient, has no authority in the carrying out of that care. The nurses are told that they are responsible only to the administration. Therefore, the doctor can be ignored—if his orders are not carried out correctly or efficiently, he can only report it to the nursing office, but he has no authority himself over the care his patients receive.

The handling of medications is set up by the administration without approval of the medical staff. Equipment needs are subject to approval by lay people who are incapable of evaluating the need and endless delays occur.

This is not a local problem. I have talked to physicians from all parts of the nation and find this problem very widespread. In fact, our section is probably more fortunate than most.

A wise and experienced surgeon said to me some time ago, "We have lost control of our nurses and now we are losing control of the hospitals."

(Turn to page 444)

JOURNAL OF THE
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EDITORIALS

The Interstate Commerce Clause: An Analgesic-resistant Headache

I

When the founding fathers of the nation agreed that the Constitution ought to permit the federal government to regulate commerce among the several states, they created a legal headache for which nobody will ever find an adequate analgesic. Since the days of Chief Justice John Marshall, who moved the Supreme Court out of a room in the basement of the Capitol by asserting its right to interpret the Constitution, successive Courts have depended upon the celebrated "interstate commerce clause" for hundreds of decisions.

With case law built upon case law, the question of whether anyone is in interstate commerce is frequently rhetorical, and some executive agencies of government have seized upon this regulatory power to become a law unto themselves. The whole business is spilling over into the practice of medicine, of all unlikely things, suggesting that government may also wish to get a hand in the doctor's business as well as his practice.

The first ripple on the placid pond was noticed a couple of years ago in Indiana when field representative of the U. S. Department of Labor evinced an unusual interest in employment arrangements between physicians and their office assistants. The issue at hand was compliance with the Fair Labor Standards Act by the physicians. Application and enforcement of the act are, of course, related to proof of engaging in interstate commerce. The FLSA is the federal enforcement basis for minimum wages, overtime pay, records-keeping, and various other employment standards which businesses engaged in interstate commerce are obliged to honor. This was as confusing as it was vexing, because a physician in Muncie, Indiana, finds it difficult to believe that caring for his patients locally bears any resemblance to the manner in which U. S. Steel makes and markets its products.

Until AMA got into the picture, the zealous Labor Department representatives apparently went their merry, singular-purpose way. After all, there really didn't need to be a reason: It was the system that counted.

II

When, at the Houston Clinical Convention in 1967, the Indiana delegation presented the matter to the AMA House of Delegates in Resolution 47, other state medical associations began to appreciate the unpalatable potential which the problem represented. The AMA Law Division was asked to study the entire matter, and only recently, at the San Francisco Annual Convention last June, a full and comprehensive appraisal of the situation emerged.

As with some other mysteries of federal law and especially, its application and interpretation,

it really doesn't matter whether the physician-employer is in interstate commerce or not when it comes to the Fair Labor Standards Act. It is a question of *whether the physician's employees are engaged in interstate commerce.* A further strain on credibility is the fact that the Labor Department has extended this definition to cover almost *all* employees.

The AMA legal study seems both optimistic and pessimistic about all of this. Said the report: "Whether physicians' employees are covered by the FLSA has no bearing, from a legal viewpoint, on the issue of whether physicians could be subjected to federal regulation. It does not appear, at this time, that the courts would uphold a federal law governing the licensing of physicians, since this is well-established as a matter within the exclusive jurisdiction of the states.

"There is little doubt, however," the study notes pessimistically, "that the courts would sustain federal regulation of the socioeconomic aspects of medical practice if the Congress chose to enact such legislation."

Generally, physicians are good and generous employers, so there is no widespread question of inadequate compensation of nonphysician medical assistants. AMA says that it is neither desirable nor practical for physicians to pay their help less than the going rate in comparable business pursuits, and it is unlikely that a physician could assure himself of suitable staff if he were to do so.

III

In the course of its study, AMA consulted the Solicitor of Labor, the department official charged with enforcement of the FLSA. He would not, according to the report, make a general interpretation that physicians' employees were totally exempt from FLSA provisions, but he indicated a belief that they are not under it in many instances. He did go so far as to say that doctors of medicine have not been singled out as enforcement targets, nor did his department have plans to make them such.

The Solicitor did have positive statements on two key aspects of the matter. First, he said that physicians' employees or those of any employer are subject to FLSA "if they regularly and recurrently spend more than a negligible amount of time in preparing, sending, or receiving communications to or from other states by telephone, telegraph, or mail."

Second, the Solicitor took the position that employees of a physician cannot be exempted from the requirements of the FLSA as employees of a retail service establishment. Although a number of court decisions are in direct conflict with this view, it is notable that the U. S. Department of Labor generally does not recognize as binding, as regards the FLSA, decisions of federal courts below the U. S. Supreme Court.

IV

AMA attorneys have this general advice for physicians who may encounter a Labor Department investigation. Voluntary conformity with FLSA minimums by physician-employers is suggested. While there are no comprehensive data available, it is believed that a vast majority of doctors are already meeting these minimums in employment conditions and employee compensation. Voluntary conformity, says AMA, can and does minimize the possibility of *any* governmental action against physicians under the Fair Labor Standards Act.

Second, advises AMA, a physician should immediately consult his attorney when confronted with an allegation that he is in violation of FLSA. Such charges should be resisted, but always with legal guidance. In a number of instances which AMA has been able to document, the Labor Department has terminated investigations and enforcement actions against physicians who called in their lawyers and met the issue forthrightly.

This matter is but one of thousands where medical organization is guarding the ramparts of professional prerogative and the legal rights of its members. More than that, it illustrates the day-to-day vexations which are endured in medical practice. And it's a classic example of the tortured logic of interstate commerce, a headache not likely to be cured in the immediate future.—R.B.K.

Those Party Platforms

A good laugh is getting harder to come by nowadays as the nation moves from crisis to crisis. The quadrennial presidential campaigns seems to emphasize the country's woes, too, so it's a refreshing experience to hear about someone who can provoke a smile out of all our troubles.

Take, for example, the Philadelphia, Pa., disc jockey who had these jolly suggestions for the major party platforms. Even if not always entirely practical, his solutions stir up a little thoughtful contemplation after tickling the funnybone. Here's how he would deal with major issues, including health:

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nation which doesn't agree with us. Not only does this erase the problem but it also lowers our weapons inventory, a goal in disarmament.

—*On the gold drain:* Forget it, because stainless steel is the current precious metal. Just price the razor blades, a new kitchen sink, or any of these stainless products.

—*On civil rights:* No problem at all, just paint everybody green.

—*On the dual problem of taxation and welfare costs:* Simple, just pay everybody in the United States $5,000 per year as a matter of right and double the taxes on low incomes.

—*On Medicare:* Alternate each year giving these benefits to younger groups, taking care of the seniors every other year. This will cut a piece of the pie for the pediatricians and obstetricians who were left out.

—*On foreign aid:* Make the potential recipient government appear before Fulbright's committee in the Senate. At least, they will have earned part of what they get.

—*On gun control legislation:* It should never be passed, because it's nothing but a conspiracy by the bow and arrow lobby.

Come to think of it, this same bird may *have* been consulted by the Democrats and Republicans who wrote those platforms.—R.B.K.

New Hospital Uses, at Higher Costs

The American public has shown a marked change in the nature of its demand for health care services in hospitals as it continues to use with greater frequency outpatient facilities. The American Hospital Association's annual survey of hospital activities disclosed that last year, there were 749 outpatient visits in hospitals for every 1,000 population.

The astonishing total of these outpatient visits in 1967 came to an astronomical 148 million plus. On the other hand, inpatient admissions remained fairly stable, with a mean of 148 per 1,000 population. The impact of Medicare seems to have leveled out, as the number of admissions in 1967 advanced only 1 per cent over 1966. Indirectly, this means that medicine is doing a better preventive job, too, because the population increase exceeds this modest change by a substantial margin. More than 29 million Americans were admitted to hospitals in 1967.

AHA provides other useful data in the most recent survey by comparing hospital utilization and costs for 1967 against 1965. To absolutely nobody's surprise, costs went up more than 21 per cent in these fateful 24 months, saw progressively higher minimum wage laws and inflationary spirals. Perhaps Medicare was something of a culprit in increasing the mean length of stay to 8.2 days over the 1965 level of 7.8 days. As a consequence, the number of admissions per bed in community hospitals declined to 34.2 from 35.7 in 1965.

But two factors were chiefly responsible for the upward press of hospital costs. These were (1) more employees at (2) higher wages. In 1967, the combined total of all hospital payrolls in the United States was $10.4 billion, about a third of the nation's entire outlay for health, medical, and health-related services.

The per patient day cost average in hospitals has risen to $58 over $44 two years previously. Many authorities feel that per diem costs may hit $100 in hospitals in the late 1970's, and the trend is there to lend credibility to their forecasts.

In the meanwhile, both the profession and the medical care-consuming public are making greater use of hospitals in the extension and expansion of all health care services.—R.B.K.

PMA Says Update PDR–PDQ!

While the Food and Drug Administration, many members of the Congress, and an assortment of others have fretted over a federal drug compendium, the Pharmaceutical Manufacturers Association got busy and asked physicians what would serve them best. After all, reasoned PMA, doctors of medicine are the real and steady users of compendia on drugs, and they, above others, ought to have a say-so about them.

PMA retained the services of the respected Opinion Research Corporation to make a determination on the national attitude of private medicine over drug compendia. What's more, PMA said *prior* to the survey that it would work to achieve what physicians wanted.

The findings are interesting. ORC discovered that 64 per cent of the privately practicing physicians believe that existing compendia are adequate, and an additional 21 per cent feel that revision or expansion of existing information sources would be helpful. Less than a sixth—15 per cent—favor development of new compendia, and only 6 per cent said that the federal government should do the job.

The *Physicians' Desk Reference* is the top drug

information source by a landslide with four out of five doctors reporting that they use it most often. One physician in 10 says he uses AMA's *New Drugs,* the *Merck Manual,* or the *Medical Letter.* Other compendia are used by practitioners only occasionally, if at all.

C. Joseph Stetler of Washington, president of PMA, concurs in the need for revisions in the popular PDR. "We agree, for example," Mr. Stetler said, that PDR should include a separate list of drugs that are most often prescribed generically, that additional drugs be added to make the volume as comprehensive as practical, and that every piece of 'negative' information about a drug contained in the approved package insert also be a required part of the description in the PDR entry."

Mr. Stetler believes that revision of existing compendia would be least disruptive or confusing to physicians' present prescribing practices and that this could be accomplished at much less cost and with far greater speed than an attempt to prepare and publish an entirely new work.

Pointing out the boon this direction would mean to FDA, Mr. Stetler also underscored ORC's finding that more than half of the nation's physicians believe that this task could best be undertaken by a consortium of nongovernmental medical and scientific organizations.

Finally, PMA seeks a further goal of usefulness by adding to information provided on indications, dosages, and contraindications. A pilot project is now in progress aimed at finding a method, other than through the use of compendia, for supplying drug price information for physicians and the public.

As with other leadership achievements in its field, the Pharmaceutical Manufacturers Association is to be saluted for its logical approach to this problem and its consultations with the medical profession in this important information system.—R.B.K.

Dangerous, But Profitable

It's only a 60 cent taxi ride between the United States Public Health Service at 4th St. and Independence Ave., S.W., in Washington and the Department of Agriculture, located on the Mall between 12th and 14th Sts., S.W. But there is a $23.7 million difference between these two executive departments when it comes to tobacco and cigarettes.

The Public Health Service has reported new and impressive evidence on the harmful effects of cigarette smoking, asking the Congress to make



THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

the warning on fag packages stronger. The American Cancer Society, picking up a cue, has asked that cigarette advertising be banned from television. The Federal Trade Commission isn't opposed to making the health hazard warning a mandatory part of cigarette advertising in newspapers and magazines.

But the wonderfully mysterious ways in which the wheels of our government turn furnish us with many faces. In this case, the other face is at the Department of Agriculture where, during the first 10 months of the fiscal year just ended, $23.7 million was paid in production and export subsidies for tobacco. In fiscal 1967, the taxpayers footed a $40 million bill for the benefit of tobacco producers.

The figures aren't available, but it is generally recognized that the Public Health Service doesn't have anything like this kind of money for education on smoking and health.

We wish no farmer or manufacturer ill, but it does seem as if the government could stop the hypocrisy of using the taxpayers' money to aid and abet the production and manufacture of a product which it also says is harmful to health. This tobacco problem is demonstrably dangerous, but it is also highly profitable—the government assures that.—R.B.K.

PRESIDENT SPEAKING

(Continued from page 438)

The A.M.A. and almost every State Medical Association have urged that physicians be designated as members of the hospital's board of trustees to better communication, but little has been accomplished. Some administrators would do well to realize that they are responsible for the environment and the doctor is responsible for patient care. To assume this responsibility, it is essential that all matters pertaining to patient care be under the control of the medical staff.

All of these unpleasant circumstances make everyone appreciate a well-managed hospital *where each member of the team is primarily interested in whole-hearted cooperation for the patient's welfare* and carries out his responsibilities without wrongful restrictions upon the necessary authority of others. ★★★

POSTGRADUATE CALENDAR

September 13, 1968

PERITONITIS SEMINAR

This postgraduate education symposium will deal with problems related to various aspects of peritonitis. Guest lecturer will be Dr. Claude E. Welch of Boston, Mass., clinical professor of surgery, Harvard Medical School and visiting surgeon, Massachusetts General Hospital.

ARTHRITIS SEMINAR

University Medical Center, Jackson
October 3-4, 1968, beginning at 9 a.m.

Sponsored by the Mississippi Chapter, Arthritis Foundation and The University of Mississippi School of Medicine

Participants:

Charles A. Rockwood, Jr., M.D., associate professor and head of the division of orthopedic surgery, The University of Texas Medical School at San Antonio

Charley J. Smyth, M.D., professor of internal medicine and head of the rheumatic disease section, University of Colorado Medical Center, Denver

Thomas E. Weiss, M.D., Department of Internal Medicine, Ochsner Clinic, New Orleans

William Flowers, M.D., assistant professor of radiology, University Medical Center

Hugh C. McLeod, M.D., instructor in radiology, University Medical Center

Robert D. Sloan, M.D., professor of radiology and chairman of the department, University Medical Center

Ben J. Piazza, RPT, director of physical therapy, University Medical Center

Thursday Morning

LOW BACK SYNDROMES
Dr. Smyth

RADIOLOGIC FINDINGS IN LOW BACK SYNDROMES
Dr. Sloan, Dr. Flowers

SURGICAL MANAGEMENT OF LOW BACK SYNDROMES
Dr. Rockwood

Thursday Afternoon

DEGENERATIVE ARTHRITIS
Dr. Weiss

RADIOLOGIC ASPECTS OF DEGENERATIVE ARTHRITIS
Dr. Sloan

DEGENERATIVE ARTHRITIS
Dr. Rockwood

Friday Morning

POLYMYALGIA RHEUMATICA
Dr. Weiss

CERVICAL AND THORACIC OUTLET SYNDROMES
Dr. Sloan, Dr. McLeod

SHOULDER GIRDLE SYNDROMES
Dr. Rockwood

PHYSICAL THERAPY DEMONSTRATION
Mr. Piazza

Friday Afternoon

MEDICAL GRAND ROUNDS
HYPERURICEMIA AND RELATED SYNDROMES
Dr. Smyth

CIRCUIT COURSES

NORTHERN CIRCUIT

GREENWOOD—October 24, October 31, November 7, Greenwood Leflore Hospital, 7 p.m.

TUPELO—October 25, November 1, November 8, North Mississippi Medical Center, 7 p.m.

Session 1—Diagnosis and Management of Anemia
In Adults, Dr. Guy Gillespie
In Children, Dr. Robert Carter

Session 2—Renal Trauma
Management of Traumatic Renal Shutdown, Dr. John Bower
Surgical Aspects of Urinary Tract Trauma, Dr. Lamar Weems

Session 3—Hyperthyroidism
Medical Management, Dr. Herbert Langford
Surgical Management, Dr. J. Harvey Johnston

FUTURE CALENDAR

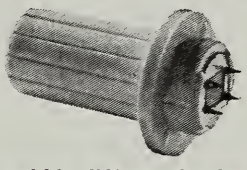
October 15-17, 1968

MISSISSIPPI ACADEMY OF GENERAL PRACTICE

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

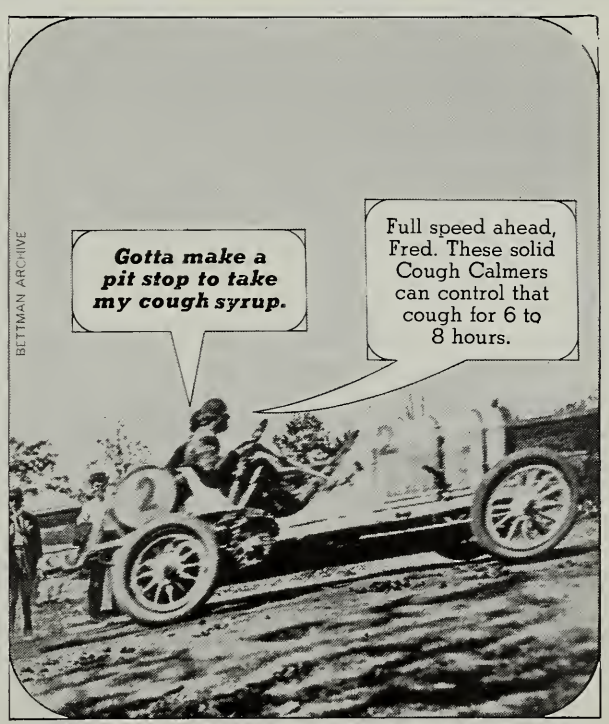
HISTOPLASMIN, TINE TEST
(Rosenthal)

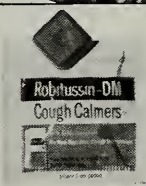
The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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A·H·ROBINS

POSTGRADUATE / Continued

October 24 and 31, 1968

CIRCUIT COURSE, GREENWOOD

October 25, 1968

CIRCUIT COURSE, TUPELO

November 1 and 8, 1968

CIRCUIT COURSE, TUPELO

November 7, 1968

CIRCUIT COURSE, GREENWOOD

November 8, 1968

CARDIOPULMONARY RESUSCITATION TRAINING COURSE

November 14, 1968

PEDIATRIC SEMINAR

PERSONALS

W. H. ABRAHAM, JR., of Meridian has announced the opening of his offices at 1413-22nd Ave. He limits his practice to obstetrics and gynecology.

BARRY B. ADEN has become associated in practice with Anesthesia Associates, 1151 N. State St., Jackson. Dr. Aden joins THOMAS J. MARLAND, RICHARD C. SNOW, CLARENCE H. WEBB, JR., DOYLE P. SMITH, RALPH E. DUNN, and JAMES F. SAVAGE, JR., in the group.

FRANK W. BOWEN of Carthage has announced the association of JERRY T. RUSSEL in practice at 303 W. Franklin St.

JACK B. CAMPBELL of Jackson has announced that EDWARD M. LOWICKI has become associated with him in practice limited to general, thoracic, and cardiovascular surgery at 1815 Hospital Drive.

JOHN H. CAMPBELL, WAYNE G. ELLIOT, and CHARLES A. MARASCALCO have associated themselves with the Vicksburg Clinic. Dr. Campbell will limit his practice to general and vascular surgery, while Dr. Elliot joins the Department of Anatomical and Clinical Pathology. Dr. Marascalco will limit his professional activities to internal medicine and gastroenterology.

MARION E. COCKRELL, JR., has joined the group at the Medical Center, 535 N. 5th Ave., Laurel. He will limit his practice to obstetrics and gynecology.

JAMES T. DOSTER has announced the opening of his offices in the Medical Arts Center, 221-7th St., North, at Columbus, where he will limit his practice to obstetrics and gynecology.

C. MIMS EDWARDS has opened his offices at the Medical Tower, 440 E. Woodrow Wilson Dr., Jackson, where he will limit his practice to psychiatry.

FRANK S. ELGIN has assumed his new duties as county health officer for Copiah, Jefferson, and Simpson counties with offices at Hazlehurst. He is a graduate of the University of Mississippi, and he earned his M.D. degree at the University of Tennessee College of Medicine. He interned at Baptist Memorial Hospital at Memphis where he also did work in pathology.

WILLIAM E. GODFREY, II, DONALD E. KILLELEA, and LOUIS C. LEHMANN of Natchez have announced the association of THOMAS L. PURVIS, JR., in their group located at 172 Sergeant S. Prentiss Dr. Dr. Purvis will limit his practice to obstetrics and gynecology.

ARCHIE C. HEWES and EDWARD C. HAMILTON of Gulfport have announced the association of GEORGE HANCOCK in the practice of general and thoracic surgery. The group, located at 14th St. and 25th Ave., has been redesignated the Hewes, Hamilton, Hancock Clinic. Dr. Hancock received his medical degree at the Vanderbilt University School of Medicine and his specialty training at the University of Virginia and the University of Iowa Hospital.

VERNER S. HOLMES of McComb has been named by Governor Williams to succeed himself for a 12-year term on the Board of Trustees of Institutions of Higher Learning.

LEROY HOWELL of Starkville has announced the association of ANDY E. KIRK in the general practice of medicine. Their offices are located on Hospital Drive.

J. D. HUTCHINS has opened his offices in New Hebron for the general practice of medicine.

JOHN E. LINDLEY of Meridian has announced the association of ELBERT M. JONES at the Woman's Clinic, 2216-14th St. Drs. Lindley and Jones limit their practice to obstetrics and gynecology.

Estelle Magiera of Jackson retired as director of mental health services at the Mississippi State Board of Health on Aug. 1. She interrupts a career of 28 years in Mississippi, planning to return to consultative work in child psychiatry. Previously trained in her specialty field, Dr. Magiera entered a child psychiatry residency in 1943 to prepare herself professionally to organize the State Board of Health's child guidance program. She is a member of the Central Medical Society, the state medical association, and AMA.

John McFadden opened his offices at 218 W. Broad St., West Point, where he will limit his professional activities to the practice of pediatrics.

S. Ray Pate, Jr., has opened his offices at 385 Medical Drive, Jackson. He limits his practice to psychiatry.

E. Leonard Posey, Jr., F. Earl Fyke, Jr., and S. L. Stephenson, Jr., of Jackson have announced the association of William M. McKell in the practice of internal medicine and gastroenterology. Offices of the medical group are located at 746 Manship St.

Richard A. Roberts of Moss Point has been named vice chairman of the 1968 United Fund Campaign for Jackson County. The campaign goal has been set at $193,000 which includes medical and health-related programs of $33,000 for the medical aid association, $11,000 for cerebral palsy, $2,000 for the Mississippi Children's Home, and $2,000 for the Jackson County Mental Health Association.

Edward V. Ross of Biloxi has been certified by the American Board of Radiology. He received his premedical and medical training at the Tulane University and completed his fellowship in radiology at the Ochsner Foundation Hospital at New Orleans.

Joe M. Ross, Jr., and S. Kimble Love have joined the staff of the Street Clinic at Vicksburg. Dr. Ross, a Jackson native, received his M.D. degree from the University Medical Center and his specialty training in internal medicine at the Baptist Memorial Hospital, Memphis. Dr. Love received his medical and postgraduate training in pediatrics at the University Medical Center. He is a native of Itta Bena.

Jack Sartin of Clarksdale has announced the association of James W. Sanders in the practice of general and thoracic surgery. Their offices are located at 110 Yazoo Ave.

Ralph Sneed and Howard B. Cheek of Jackson have announced the association of James D. Gordon at the Jackson Ear, Nose, and Throat Clinic, 916 N. State St. The group limits its practice to otolaryngology.

James W. Speck has opened his offices at Ecru for the general practice of medicine.

A. P. Srabery has begun general practice at his hometown, Fulton, occupying the offices of the late W. J. Daniel. He received his premedical education at Ole Miss and his M.D. degree from the University Medical Center. His internship was completed at the Mississippi Baptist Hospital, Jackson.

Van C. Temple and George W. Herring of Hattiesburg have announced the association of John R. Jackson in practice limited to pediatrics. Their offices are located in the Medical Arts Building at 405 S. 28th Ave. Dr. Jackson is a graduate of the University Medical Center, and he received his specialty training at Baylor University Hospital.

James D. Wakham has opened his office for the general practice of medicine at 105 E. 1st St., Newton. He is a graduate of Ole Miss and the University Medical Center. Dr. Wakham has recently completed two years with the U. S. Public Health Service.

Charles E. Ward, Noel C. Womack, Jr., William F. Sistrunk, Jim G. Hendrick, and Weir Conner, III, of Jackson have announced the association of Robert L. Abney at the Children's Medical Group, 800 Carlisle St. The group limits its practice to pediatrics.

Dayton E. Whites of Lucedale won the third place trophy in the recent Deep South Antique Automobile Association show at Mobile. His prize-winning 1926 Motel T Ford, which he has restored, was among 100 entries.

John R. Young, Jr., has announced the opening of his offices at 55 Sergeant Prentiss Drive, Natchez, where he limits his practice to otolaryngology.



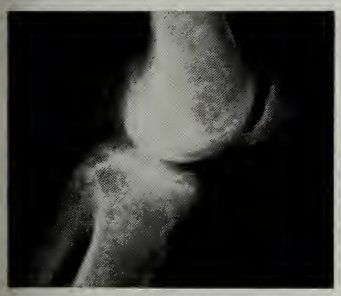
Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

"Pain Break" for an osteoarthritic.

Tandearil can usually ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

vate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

For complete details, please see full Prescribing Information.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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DEATHS

GOOGE, JAMES TURNER, Jackson. M.D., University of Tennessee College of Medicine, Memphis, 1911; received a Certificate of Public Health from Harvard University, School of Public Health, 1933; practiced in Mississippi from 1911-1934 during which time he was in general practice in Booneville, in Public Health Service, and associated with the Mississippi State Board of Health; died July 29, 1968, aged 79.

HALL, MARVIN MONTGOMERY, Swiftown. M.D. Memphis Hospital Medical College, Memphis, Tennessee, 1909; died May 17, 1968, aged 87.

STRINGER, JOSEPH W., Stringer. M.D., Louisville Medical College, Louisville, Kentucky, 1909; died July 23, 1968, aged 88.

WELCH, BENTON ZACHARIAH, Biloxi. M.D., Tulane University School of Medicine, New Orleans, Louisiana, 1907; postgraduate study, Tulane University, New Orleans, Louisiana, 1924; member Fifty Year Club; Emeritus member Mississippi State Medical Association and American Medical Association; died July 19, 1968, aged 89.

PHS Publishes Emphysema Research

Recent research into the causes and progressive nature of emphysema and other chronic lung diseases is the subject of a new 400-page publication just released by the National Center for Chronic Disease Control, Public Health Service.

"Current Research in Chronic Airways Obstruction" (Public Health Service Publication No. 1717) contains 30 papers presented at the 9th Aspen Emphysema Conference, held in Aspen, Colorado, June 9 to 12, 1966.

Beginning in 1958, a group of 100 national and international experts in chest medicine, physiology, biochemistry, and other medical specialties have assembled in Aspen each June to discuss research projects in chronic lung disease and their clinical experience in caring for patients.

The Chronic Respiratory Diseases Control Program, sponsor of the last three conferences and of the 11th conference held June 12 to 15, this year, is the publisher of the current volume of studies.

A limited number of single copies of "Current Research in Chronic Airways Obstruction" are available from the Public Inquiries Branch of the Public Health Service, Washington, D. C.

AMA, AAMC Seek Expanded Education

As part of their continuing campaign to increase the number of physicians in the nation, the AMA and the Association of American Medical Colleges have urged that medical schools give increased emphasis to educational functions.

At the same time, the two associations predicted that first results of the campaign will enable some 200 more freshmen to enroll in medical schools this year as compared to 1967. By 1969 another increase of over 400 is expected. (Total enrollment in first-year classes in 1967 was approximately 9,475.)

In their joint statement, the AMA and AAMC recognized that a medical college is "a complex, multi-purpose enterprise with important obligations to individuals, various groups, organizations and to society." But they urged that the production of physicians and other health personnel be assigned the highest possible priority.

The statement noted that five new medical schools opened their doors in 1967, and that five others are expected to begin operation this fall. Appropriate plans for organization of additional medical schools "should continue to be strongly encouraged," the two associations said.

NEW MEMBERS

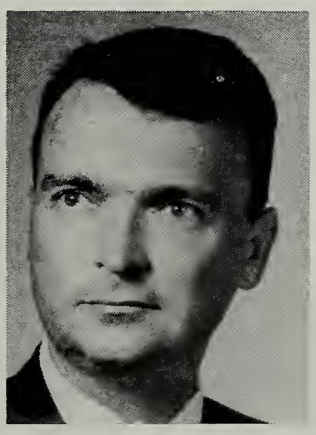
The following physician has been elected to membership by his component medical society in the Mississippi State Medical Association and the American Medical Association.

HOCKADAY, PERRY JONES, Pascagoula. Born Trenton, Tennessee, July 23, 1934; M.D., University of Tennessee College of Medicine, Memphis, 1959; interned Mobile General Hospital, Mobile, Alabama, one year; general surgery residency, Mobile General Hospital, Mobile, Alabama, four years; elected May 1, 1968 by Coast Counties Medical Society.

Governor Williams Appoints Dr. Cobb Comprehensive Health Planning Director

Dr. Alton B. Cobb of Jackson has been appointed director of Comprehensive Health Planning for Mississippi. He was named to the post by Governor John Bell Williams.

For 10 years, Dr. Cobb has served on the professional staff of the Mississippi State Board of Health. He leaves the directorship of the Division of Chronic Illness Services.



Dr. Cobb

The new activity, a division of the office of Federal-State Relations in the executive office of the governor, will administer the state's role in Comprehensive Health Planning, a U. S. Public Health Service program enacted by the Congress in 1966. Better known as the "Partnership for Health" Act, CHP enables a state to marshall its full resources among local, state, public, and private groups and agencies in health services. Mississippi was the 50th and last state to implement the program.

Dr. Cobb is a native of Madison County and a graduate of the public schools and Holmes Junior College. He received his premedical education at Ole Miss and his medical degree from the Johns Hopkins University. He earned the Master of Public Health degree from the Tulane University School of Medicine, and he is a diplomate of the American Board of Preventive Medicine.

Active in the Mississippi State Medical Association, Dr. Cobb is a member of the Health Insurance Benefits Advisory Committee, a body of the Council on Medical Service. He is chairman of the Regional Advisory Body of the Mississippi Regional Medical Program under the University Medical Center.

In announcing the appointment, Governor Williams said that the new division under his office will exercise a role "in identifying our health needs and proposing solutions for these needs.

"I am sure," the governor continued, "this program will win the same support from medical and health professionals and from the people of Mississippi which it has gained in the other 49 states where it has been implemented."

Association officials have noted that since 1967, MSMA has urged implementation of Comprehensive Health Planning as the most desirable method of the state's conducting a searching reappraisal of its fragmented health programs and as the most effective means for determining the organization and structure of a Title XIX program.

The announcement said that the first task of Dr. Cobb's office will be the making of recommendations for Title XIX. It is generally conceded, although no formal announcement has yet been made, that a special session of the Legislature on health will be called, principally to deal with Title XIX prior to the Jan. 1, 1970, deadline for implementation of the enactment.

The Partnership for Health Act provides states with USPHS block grants with which to finance programs. This enables the state to chart its own course, make determinations based upon its own estimates of local need, and to shape its programs in accordance with local findings.

The new division is part of the office of the Coordinator of Federal-State Relations headed by David R. Bowen. The new activity was created by Governor Williams in fulfillment of a campaign pledge to oversee a business-like management of federally-assisted programs which may be implemented by the state. The new office has placed early emphasis on health and health-related activities.

A blue-ribbon commission, authorized under Senate Concurrent Resolution 129 by the 1968 Regular Session of the Legislature, has already

asked for studies on Title XIX. Dr. Temple Ainsworth of Jackson, 1967-68 president of the association, was appointed by Governor Williams to represent medicine on the commission. It also includes representatives of other professional organizations, the State Board of Health, the University Medical Center, concerned agencies of the state, and eight members of the Legislature.

Dr. Cobb said that studies for the commission and his office have already been authorized and that initial reports on which recommendations will be based are expected in early 1969.

Cleta Brinson Is Named MPHA Chief

Cleta Brinson of Jackson, who has served as executive secretary to three of Mississippi's four state health officers, has been named president-elect of the Mississippi Public Health Association. The action came at a recent special meeting called for that purpose.



Miss Brinson

MPHA is a professional organization of those in preventive medicine made up of 900 physicians, nurses, engineers, sanatarians, technicians, and administrative personnel.

Hailing from Monticello, Miss Brinson was reared at Clarksdale and was graduated from the Mississippi State College for Women with the B.A. in mathematics. She was first associated with the State Board of Health in library sciences but soon was named secretary to the then-health officer, the late Dr. Felix J. Underwood. She served in the capacity of executive secretary to the late Dr. A. L. Gray and has since been designated administrative assistant of the executive officer.

Commending Miss Brinson's effective service, Dr. Frank J. Morgan, Jr., assistant state health officer, said that "her knowledge of public health and the workings of the central office (of the State Board of Health) are positively amazing."

Closely associated with the privately practicing medical community, Miss Brinson has served as recorder of the House of Delegates of the Mississippi State Medical Association during the past 17 consecutive annual sessions. She also has been a key figure in working with the reference committees of the House and in assisting in preparing the Transactions of each annual session for publication each year.

Miss Brinson will be inaugurated as MPHA president at the 31st Annual Meeting in October.

MSMA Is Represented at Care Cost Conference

Dr. C. D. Taylor, Jr., of Pass Christian, chairman of the state medical association's Board of Trustees, has been named a member of the planning and program committee organizing the southern regional meeting on medical care costs. The meeting series is sponsored by the Social Security Administration.

In announcing the meeting series of which the Atlanta conclave, set for Oct. 3-4, is the second, the Social Security Administration said that all members of the health care team concerned with Medicare will be invited to participate.

The planning group includes 18 members representing state medical associations, hospital associations, the Public Health Service, Social Security Administration, labor, consumer groups, the health insurance industry, and government.

Participation in the conference is by invitation, but initial announcements disclosed that leadership segments of both the private and public sectors concerned with health care will be asked to participate.

The conference will analyze medical care cost components, especially as relate to Parts 1-A and 1-B of Medicare. The Atlanta regional meeting will cover the southeastern states. The first of the meeting series was conducted at Kansas City in late June.

SBH Will Study Immunization Progress

A survey to evaluate progress in the immunization level of Mississippians over the past five years will soon get under way in 13 counties, according to Dr. Hugh B. Cottrell, state health officer.

In 1963, State Board of Health interviewers questioned some 25,000 Mississippians as to how many of the basic immunizations they had had. An intensive immunization program was launched in 1964.

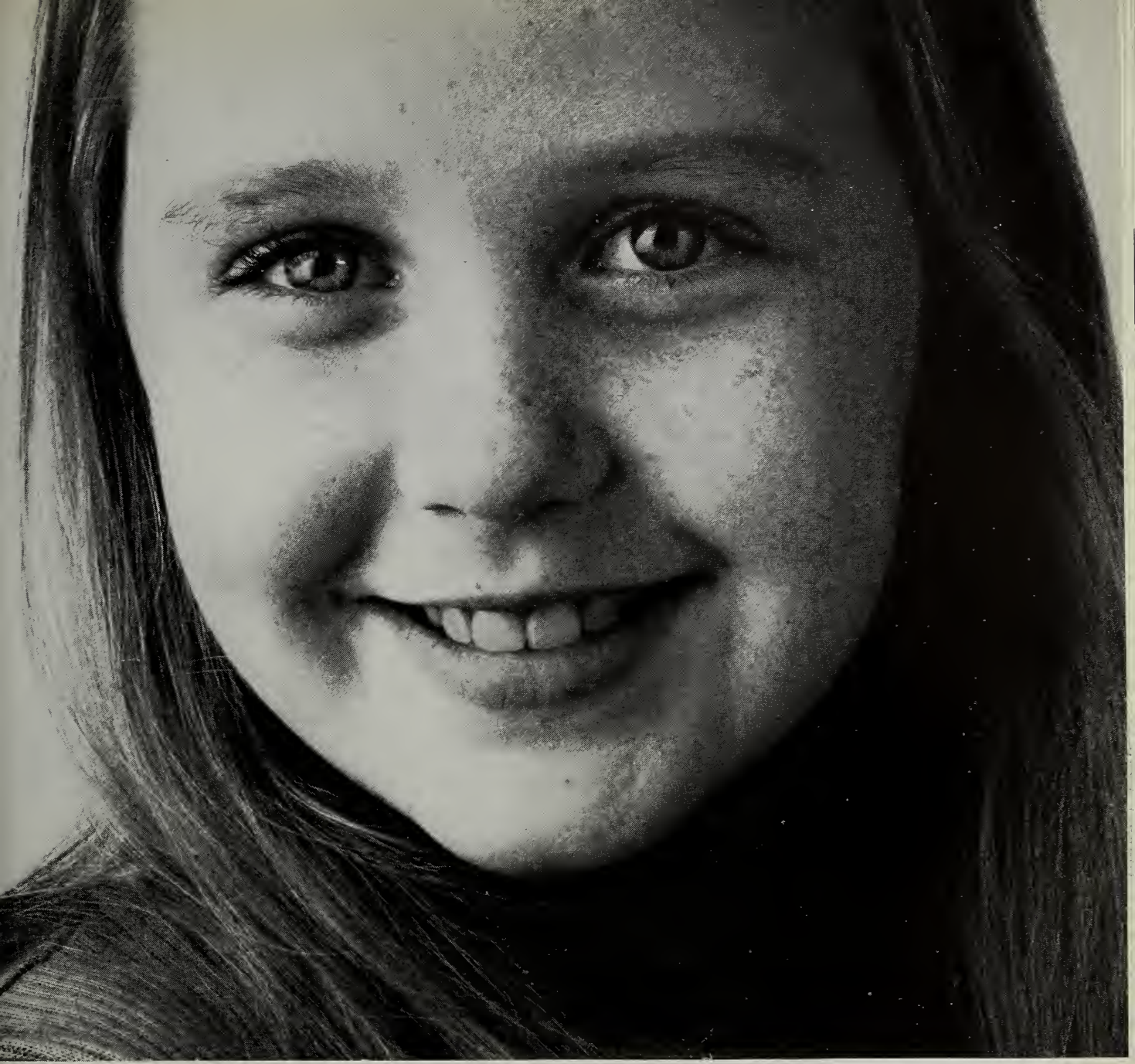


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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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"Now," said Dr. Cottrell, "we will evaluate progress made as a result of this intensive immunization, as well as the educational and promotional effort that went with it, in which the importance of immunization was stressed."

He said counties to be surveyed include Adams, Carroll, Claiborne, DeSoto, Grenada, Holmes, Jefferson, Panola, Tate, Warren, Wilkinson, Yalobusha and Yazoo.

These counties make up the Bluff Region—one of the five regions into which the state was divided for the 1963 survey. Other regions were the Delta, northeast, south central, and coastal areas of the state.

"Data obtained from this survey will be evaluated by the National Communicable Disease Center in Atlanta, will be projected to the statewide population, and then compared with the 1963 data," said Dr. Cottrell.

He said State Board of Health teams will interview members of some 1,200 families in the 13 counties, selected to give representative samplings by race, age groups, and rural-urban population.

"By using the vaccines we already have," said Dr. Cottrell, "we have the means to practically wipe out such diseases as polio, diphtheria, whooping cough, tetanus, smallpox and measles.

"This survey will show us who the unvaccinated are—and where they are. It will give us the data we need to determine best use of new vaccines which may soon be available."

Dr. Cottrell urged families contacted in the 13-county area to cooperate with the State Board of Health interviewers, who will be working out of the county health department in each county. He said advance announcements will be sent to newspapers in each locality.

He said tentative plans call for the interviewers to begin in Warren county early in August, with the survey ending in DeSoto county around mid-September.

"We would assume," said Dr. Steven Moore, medical director for the project,"that the level of immunization of Mississippians has risen since 1963, but we want to know how much.

"Many Mississippians may not have kept up their booster shots. We may have had an out-migration of many people properly immunized and an in-migration of people without immunization. All these things would be factors in the changing immunization picture in the state, and we hope this survey will reveal the extent of change."

"During the 1963 survey," said Dr. Moore, "base lines for immunization were established for different diseases, and the results of the 1968 study will be compared to those base lines to determine the extent of immunization improvement in the state."

Gen. Blount Is New UMC Assistant Dean

Maj. Gen. Robert E. Blount, MC, USA (Ret.), has been named by the Board of Trustees of Institutions of Higher Learning as assistant dean of the University Medical Center. He will succeed Dr. John A. Gronvall, Jr., who has accepted a post in academic medicine in Michigan. The new UMC official is a native of Bassfield, Miss.



Gen. Blount

Gen. Blount was retired from a distinguished career with the Army Medical Corps during recent ceremonies at Fitzsimons General Hospital, his last command, during which he was decorated with the Distinguished Service Medal, the nation's highest noncombat award.

He was an honor graduate at Millsaps College and earned his M.D. degree at the Tulane University School of Medicine. After interning at the U. S. Marine Hospital at New Orleans, Gen. Blount completed his specialty training in internal medicine. He has also received training at the Walter Reed Army School of Tropical Medicine and has held faculty appointments at the Baylor University Graduate School and Medical School, the Army Medical Service Field School, and at the University of Colorado School of Medicine.

Gen. Blount is a diplomate of the American Board of Internal Medicine, and he will hold an appropriate appointment with high academic rank in addition to his primary post as assistant dean.

Married to the former Miss Alice Boyd Ridgway of Jackson, Gen. Blount has two sons, both physicians. The older, Robert E., Jr., is chief of medicine at the Wurtzburg (Germany) Army Hospital, and the younger, Richard, a 1966 graduate of UMC, is a medical resident at Fitzsimons Army General Hospital at Denver.

He is slated to assume his new duties and permanent residence at Jackson after an extended vacation.

PHS Funds Pediatric Pulmonary Centers

As part of a national effort to reduce infant mortality in the United States, the Health Services and Mental Health Administration has announced the establishment of two pediatric pulmonary centers. The centers will seek to develop methods of improving care for babies and children suffering from respiratory disease.

"Respiratory diseases are a major problem for infants," said Dr. Frank W. Mount, Chief of the Administration's Chronic Respiratory Diseases Control Program. "Of 93,000 babies who died in 1965, 31 per cent, or 29,000 died because of respiratory disease. Most of these deaths occurred during the first 28 days after birth."

The two pediatric pulmonary centers—one in Philadelphia, the other in Los Angeles—will seek to develop and improve the quality and availability of care for children with respiratory disease.

"We believe a special emphasis on pediatric respiratory disease will save the lives of many of our infants," Dr. Mount said.

By expanding its interest to childhood respiratory diseases, the Public Health Service will be able to investigate the possible relationship of respiratory disease in infancy and childhood to the development of chronic, crippling lung disease during the adult years. In the past, the Chronic Respiratory Diseases Control Program has concentrated on the control of emphysema and chronic bronchitis, two chronic lung diseases causing more than 25,000 deaths yearly.

Sharing in the $438,000 project spanning three years are the Los Angeles County-University of Southern California Medical Center and three university hospitals in Philadelphia: Hahnemann Medical College, Temple University, and the University of Pennsylvania. The two contracts are funded from a special Congressional appropriation for pediatric pulmonary centers.

ACP Sets Dixie Regional Meet

The American College of Physicians (ACP) will sponsor a regional scientific meeting for specialists in internal medicine in the southern states, Sept. 27-28, at St. Petersburg Beach, Fla.

The meeting, to be held at the Happy Dolphin Inn, will be attended by physicians from Alabama, Florida, Georgia, Louisiana, Mississippi,

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and South Carolina. It is one of 34 scientific-educational meetings sponsored by the ACP during the academic year. Held throughout the United States and Canada, the meetings help the College's 14,300 members keep abreast of developments in the basic medical sciences and in clinical medicine.

Among special guests will be Dr. H. Marvin Pollard of Ann Arbor, Mich., ACP president. Dr. Pollard is professor of internal medicine at the University of Michigan Medical School and head of the Section of Gastroenterology at the University of Michigan Medical Center.

In general charge of the meeting is Dr. Donald F. Marion of Miami, ACP governor for Florida and clinical associate professor of medicine at the University of Miami School of Medicine.

Wisconsin Adds Postpayment to Blue Shield

Wisconsin Physicians Service, the Blue Shield plan operated by the state medical society, has announced plans to experiment with postpayment financing of health care expenses as a companion to its regular health insurance coverages.

Under the plan, eligible WPS subscribers would be granted "instant credit" for needed services not paid for by their WPS contracts.

They would receive a consolidated monthly billing for health services and could budget the payments over a longer period if they wished.

The trial WPS plan will offer postpayment to eligible group subscribers. At the start, it is expected to include not only doctors' services, but drugs, dental care, special medical supplies and equipment, and possibly hospital and nursing home care.

Dr. E. M. Dessloch, Prairie du Chien, chairman of the SMS Commission on Medical Care Plans said, "We are fast closing the gaps in coverage for items of health care which are insurable. Postpayment will help those people who, although able to do so, have not budgeted for certain uninsured or partly insured costs of illness."

"This will give the patient or his family a breathing period on costs at the time when his chief concern is the best possible care for early recovery," Doctor Dessloch said.

WPS believes its present Blue Shield policies for hospital, surgical-medical care, cover about two-thirds of the sickness or accident expenses for

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its subscribers. This is twice as good as the reported national average.

Even so, many people do not buy the added coverages which WPS-Blue Shield offers, such as outpatient diagnostic services, drugs, dental care, nursing home and home care.

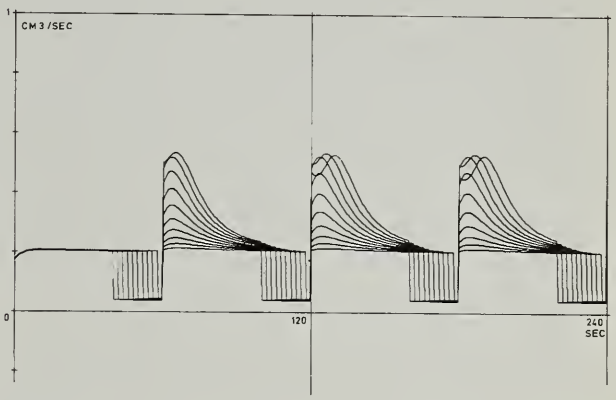
WPS leaders believe the combination of broad insurance coverage with a postpayment plan will make needed care available while holding down utilization or "frivolous use" of services.

Continuing professional review of fees and utilization will be part of the new plan as it is in present WPS-Blue Shield operations.

Belgian Researchers Simulate Coronary Occlusion

A new computer application for simulation studies of coronary artery occlusion has been developed by the Janssen Pharmaceutica at Beerse, Belgium. The research staff has successfully programmed a model which simulates blood supply to the heart after sudden occlusion and subsequent reopening of the coronary arteries.

The institute staff reports that the simulation provides autoregulation by means of arteriolar dilatation induced by a decrease of oxygen supply. The studies are made on an IBM 1800 computer, a research configuration, using a CalComp 565 plotter to display graphically the data.



Plot shows simulated coronary occlusion and time lapse in return of the blood supply to the heart. The superimposed plots represent several computer runs of the simulation under varying conditions of coronary occlusion.

The institute says that the studies have been valuable to European cardiologists and to those in drug research.



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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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Wyeth Will Sponsor Pediatrics Fellowships

To aid a number of young physicians in obtaining further professional training, the Wyeth Fund for Postgraduate Education is again granting 15, two-year residency fellowships in pediatrics.

This is the 11th group of fellows to be honored in the program established in 1958 by Wyeth Laboratories, manufacturer of pharmaceuticals and infant formulas. The Wyeth Fund awards each doctor a fellowship of $4,800 toward the expenses of undertaking advanced training in the medical care of children.

The autonomous selection committee for the Wyeth pediatric fellows program is headed by Dr. Philip S. Barba, who is adjunct professor of pediatrics, Temple University School of Medicine, and past president of the American Academy of Pediatrics.

The Wyeth Pediatric Fellows are chosen from among physician-applicants on the basis of evidence of good character, academic achievement, performance of duties, and need for financial assistance. Each is free to choose his or her place of residency from the institutions accredited by the Residency Review Committee of the American Medical Association, the American Board of Pediatrics, and the American Association of Pediatrics.

M.D. Total, Medical Schools Are Up

An estimated 7,966 June (1968) medical school graduates has raised the total U. S. physician population to 315,868. The number of 1968 graduates is an increase of 217 over the last year and 879 more than in 1960.

During the 1967-68 school year five new medical schools opened their doors. They are:

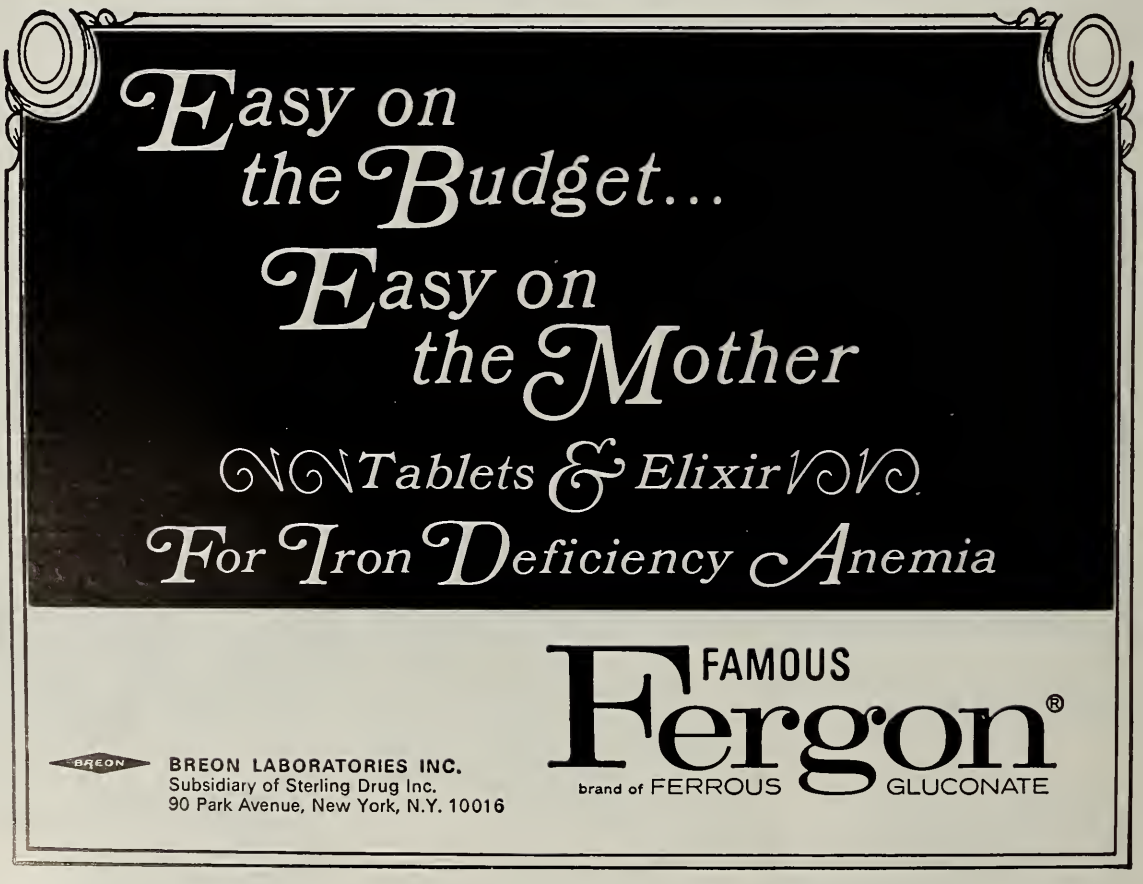
—University of Arizona School of Medicine.

—Brown University Program in Medical Science.

—University of Hawaii School of Biomedical Sciences.

—Michigan State University College of Human Medicine.

—Pennsylvania State University Milton S. Her-



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Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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shey Medical School.

This brings to 94 the total number of schools now in operation—an increase of 17 since World War II. By 1971, an additional 10 schools will be added, making a total of 104. Twenty or 30 other medical schools have been proposed.

Insurance Industry Gives Private Research Funds

More than $1.2 million in scientific grants and fellowships have been awarded during 1968 by the Life Insurance Medical Research Fund.

The Fund, supported by more than 130 insurance companies in the United States and Canada, presents the awards annually to aid basic medical research. Since 1945, more than $23 million in grants and fellowships have aided 498 institutional projects and 387 individuals.

A total of 57 medical research projects, including those of 21 individuals and 30 institutions, have received the LIMRF awards for the 1968-69 academic year. (Five institutions have received more than one grant.)

Medical scientist fellowships are presented for up to six years to medical students with records of high scholarship and an aptitude for research, who are willing to secure both the M.D. and Ph.D. degrees. This year, 21 students share approximately $340,000 from the LIMRF for specific projects.

The grant-in-aid program provides more than $900,000 to 30 institutions, seven of which are located in Canada, Mexico, and The Netherlands. Although grants provide research toward knowledge of all disease mechanisms, the Fund has long emphasized research into heart and circulatory diseases, the principal causes of death in the U. S. and Canada.

Recipients for both grants and fellowships are chosen by a 12-member Advisory Council, a group of physicians, biochemists and physiochemists from the nation's universities. The Council is headed by Dr. Carl V. Moore, professor of medicine, Washington University, St. Louis.

Chairman of the Fund is John J. Magovern, Jr., president of The Mutual Benefit Life Insurance Co., Newark, N. J. Scientific Director is Dr. William A. Sodeman, former dean and vice president for medical affairs, Jefferson Medical College of Philadelphia.



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Medical Organization **493** 101st Annual Session

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Worldwide Drug Group Is Organized

An international body of drug industry associations has been formed to work toward the understanding and solution of world-wide health problems.

"By fostering international cooperation, this new federation will contribute to advancing the health and welfare of peoples around the world," according to C. Joseph Stetler of Washington, president, Pharmaceutical Manufacturers Association.

Stetler is one of two Americans on the seven-man council of the newly-formed International Federation of Pharmaceutical Manufacturers Associations. The other is William H. Conzen, president of the Schering Corporation. They represent the PMA, one of the four founding associations.

One of the objectives of the Federation, Stetler explained, is to assist where possible in broad programs that involve the production and distribution of drugs, and "especially in the underdeveloped countries where the lack is greatest."

Another objective is to promote the further development of ethical principles and practices throughout the pharmaceutical industry world wide.

"This means we will strengthen and develop contacts with national and international organizations, both within government and the private sector," Stetler said. Pharmaceutical associations in all parts of the globe will be invited to become members.

Among areas of interest in the foreseeable future will be drug testing laboratories, reporting procedures for adverse drug reactions, advertising codes, international quality control standards, and good manufacturing practices, as well as technological aid to such international groups as the World Health Organization.

Plans for the Federation were virtually completed during a conference in Stockholm in June attended by delegates of the PMA; the Pharmaceutical Manufacturers Association of Canada (PMAC); le Groupement International de l'Industrie Pharmaceutique (GIIP); the drug industry Association for the Common Market countries; and the Pharmaceutical Industries Association (PIA), representing countries of the European Free Trade Area.

These four organizations have been meeting together since 1962 to discuss common problems and exchange information on regulatory and scientific advances in drug therapy. The Federa-

tion, which became official on August 1, 1968, consists of an Assembly, which will meet annually, and a Council, with two representatives each from the GIIP, PIA, PMA, and one from the PMAC.

First president of the IFPMA is Dr. H. Harms of the GIIP, with PMA's Stetler and F. W. Griffin of PIA as vice presidents. Other members of the Council are B. Olivier-Martin of GIIP, E. Goth of PIA and Dr. William W. Wigle, president of the PMAC.

The first annual meeting of the Assembly will be held in Rome, May 29-30, 1969. The Council will meet in Zurich on Nov. 13-14, 1968.

AAP Sets Oct. Annual Meeting

What are the new developments in treating infectious mononucleosis? What is the current status of organ transplantation? What are the pediatric aspects of cigarette smoking? And what is the significance of drug use and abuse in adolescence?

These and many other interesting and timely questions will be explored during the 37th annual meeting of the American Academy of Pediatrics in Chicago, Oct. 19-24.

More than 4,500 persons including pediatricians, their families and guests are expected to attend the meeting in the Palmer House.

Highlighting the meeting will be a diverse scientific program, 24 round table discussions, 12 seminars, and a variety of technical and scientific exhibits.

Supplementing general session presentations, will be additional timely scientific programs presented during meetings of the Sections on Allergy, Anesthesiology, Cardiology, Child Development, Diseases of the Chest, Military Pediatrics, Pediatric Pharmacology, Public Health Pediatrics, Surgery, and the Committee on Urology.

The Academy's annual business meeting will be held Wednesday afternoon, Oct. 23, at which time Dr. Hugh C. Thompson, of Tucson, Ariz., will be installed as president of the AAP.

Several awards will be presented during the meeting including the Borden Award for research in nutrition; two E. Mead Johnson Awards for outstanding pediatric research, and the C. Anderson Aldrich Award for contributions to the knowledge of child development.

The Academy is the Pan-American association of physicians certified in the care of infants, children, and adolescents.

It has more than 10,000 members in the U. S., Canada, and Latin America.



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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

October 1968

Dear Doctor:

The state medical association's largest component, the Central Medical Society, has condemned use of rainbow pills in treatment of obesity. Acting at its September meeting, the society voted against shotgun use of cardiac glycosides, thyroid hormones, diuretics, anorexiants, barbituates, amphetamines, and laxatives for the overweight.

> Almost concurrently, a federal judge dealt the rainbow pill business a crushing blow in a Texas ruling. Judge Sarah Hughes of Dallas decreed no further interstate shipment of any pill containing digitalis and thyroid hormones. AMA has consistently condemned rainbow pill regimens.

Shockwaves still emanate from 535 N. Dearborn St. in Chicago after massive shakeup of AMA's staff and organization by Board of Trustees. Dr. Bing Blasingame's leaving as chief AMA executive registered high on medical earthquake scale only to be followed by equally surprising announcement that AMPAC would be brought under AMA's roof. Look for more radical surgery on medicine's parent body.

Would you believe a Symposium on Wine and Health, complete with learned papers and distinguished investigators from Europe and U.S.? It's all set for Chicago on Nov. 9 under sponsorship of the Wine Advisory Board, an activity of the California Dept. of Agriculture. Subjects of papers suggest wine is the greatest drug since aspirin, antibiotics, and tranquilizers.

Sheep are making a painless contribution to cancer research, according to American Society for Pharmacology and Experimental Therapeutics. Society says that animals are extremely useful in studying hair loss side effects of certain anticancer drugs. Sheep's hair is continuous, like human, whereas usual laboratory animals have hair coats that are replaced seasonally.

American Diabetes Association has set Nov. 17-23 as week for 1968 detection drive and is offering local societies materials and information kits. Dreypaks, urine test strips and mailing envelopes, are offered at cost and can be obtained free for communities unable to purchase them. ADA says there are 1.6 million undiagnosed diabetics in U.S.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Pro Footballers Boast Top Major Medical Coverage

New York - Athletes of the National and American football leagues now have $50,000 major medical coverage which also extends to their respective families. This is an increase from the $15,000 maximum last year and even includes paid-in-full obstetrical care for wives. Program is strictly sickness and off-the-job injury, since playing mishaps are separately covered. Lincoln National writes NFL plan, while AFL has Mutual Benefit Life coverage.

PMA Communications Program Will Continue

Washington - The Pharmaceutical Manufacturers Association scored a first in institutional advertising, using Reader's Digest as sole medium, and plans to conduct a $1.5 million repeat campaign next year. Drug makers used eight page inserts to tell their story, and surveys showed that ads were the best read of any ever published. Copy is low-to-no pressure narrative of drug progress and benefits. New campaign schedules four more showings in RD which has world's largest paid magazine circulation.

Medicare Has New Physician Chief

Baltimore - The Social Security Administration has announced appointment of Dr. Theodore C. Bedwell, Jr., as chief medical officer for Medicare. He is a recently retired major general, coming to program for a Department of Defense assignment. Holder of the Distinguished Service Medal and AMA's Aerospace Medicine Honor Citation, new SSA medical chief will act as principal liaison officer with practicing profession.

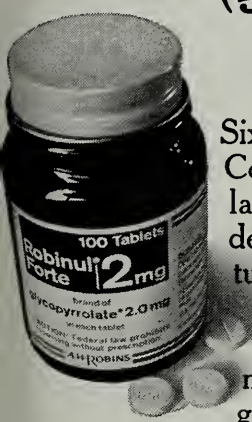
Space Components Monitor Breathing

Houston - Technological developments by the National Aeronautics and Space Administration continue to have valuable medical applications, and latest electronic miniatures, a tiny sensor and radio transmitter, will monitor windpipe obstructions, saving thousands of hours and costs of constant nurse attendance. Tiny devices attach to tracheostomy tubes, giving radio alarm at slightest clogging with mucous. Successful tests, including a four months old infant, have been conducted by Children's Hospital Medical Center at Oakland, Calif.

Part 1-B Medicare In State Shows Summer Boom

Jackson - Officials of Travelers Insurance Co., Mississippi's Part 1-B Medicare administrator, report program showed a summer jump in claims processed, and trend toward physicians accepting assignments continues to grow. July figures showed 19,300 claims paid to the tune of $830,000 with 64 per cent assignments. August volume was over 17,650 claims with 65 per cent assignment ratio.

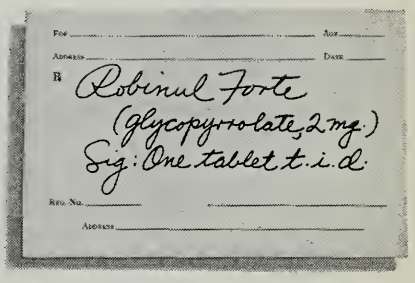
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However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



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Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.

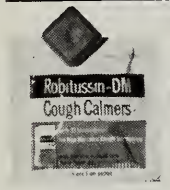


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SBH Lists Home Health Services

The director of public health nursing for the Mississippi State Board of Health said today that 58 Mississippi counties now are certified by the Social Security Administration of HEW to provide home health service.

"We believe all counties will eventually be certified, if they will apply," said Mrs. Zona C. Jelks, who is also director of Home Health Services for the State Board of Health. "No application has been turned down so far, since health departments have the potential for providing skilled nursing and other therapeutic services in the home. Applications for 21 of the remaining 24 county health departments have been submitted."

Mrs. Jelks said that the services, extended to patients over 65 who are eligible for benefits under Title XVIII of the Social Security Act, are part of a "continuum of patient care."

She added:

"Home health service represents continuity of care, from acute illness to rehabilitation. For the chronically ill, it is often the most appropriate care. The patient is often happier in his own environment. Also, the nurse can, in the process, teach members of the patient's family how to care for him properly."

She noted that patients, in every case, are under the care of a private physician who has given written orders for such care, on a part-time, intermittent basis.

"Nursing people at home, as a part of public health, is not a new concept. Here in Mississippi, we have been doing it for years—since 1921—but on a limited basis, usually by demonstration. But new laws passed in 1965 have made it possible for us to broaden the scope of such care."

The change came with the passage of Public Law 89-97 in July of 1965, which provides up to 100 home health service visits to follow up each illness involving three or more days in the hospital, if the patient is referred to the State Board of Health within a year by a private physician, via a written order.

The law also provides voluntary medical insurance, including 100 home health service visits in each calendar year, after $50 deductible has been met and after insurance pays 80 per cent of the bills, with the patient or family paying the other 20 per cent.

Since the law involves social security, the act is administered accordingly. Counties applying for certification must apply first to the Health Insur-

ance Unit of the State Board of Health and then must be approved by the Social Security unit of HEW.

"The law was passed," says Mrs. Jelks, "to improve the health care of the elderly, and it requires that the health agency provide skilled nursing service, plus other therapeutic services as needed, and that the patient be under the care of a private physician."

Development and extension of home health services began in Mississippi in January of 1966, with a grant from the U. S. Public Health Service, made to the State Board of Health, which extends the services through its public health nurses and its county health departments.

The work began in 14 county health departments where personnel could be recruited, and by July 1966, 18 county health departments had been certified as providers of home health services.

Also, two hospital-based programs had been developed—one at Northeast Community Hospital in Tupelo, and the other at the North Sunflower County Hospital in Ruleville.

By July 1 of this year, the number had risen to 56 counties, and now the number stands at 58, with certification expected soon for the other 24 counties, according to Mrs. Jelks.

"It should be kept in mind," says Mrs. Jelks, "that about nine per cent of Mississippi's population is 65 or older. Between 1960 and 1964, there was an increase of 8,000 people 65 or older. We estimate that more than 60 per cent of our 65-and-older people now have home health services available to them. Our counties certified so far range from Harrison county, with 5.3 per cent of its population 65 and over, to Yalobusha county, with 13.1 per cent of its population 65 or over."

But she adds:

"Just because a county is certified does not automatically mean that the service will be extended to all who need it. We want to urge physicians to utilize home health service. There is also the need for the creation, in each certified county, of a local advisory group consisting of physicians, nurses, hospital administrators, businessmen and knowledgeable laymen, to review policies covering skilled nursing and other therapeutic services of the Home Health Agency and its progress for recommendations and advice, and to interpret services to others in the community, and to explore ways for additional support for services to non-Medicare beneficiaries."



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Was a victim of
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Parepectolin for quick relief of acute diarrhea
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In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

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Pectin (2½ grains) 162 mg.
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Usual Adult Dose: One or two tablespoonfuls three times daily.

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Consider Esimil whenever milder agents fail to give the degree of blood pressure control you desire.

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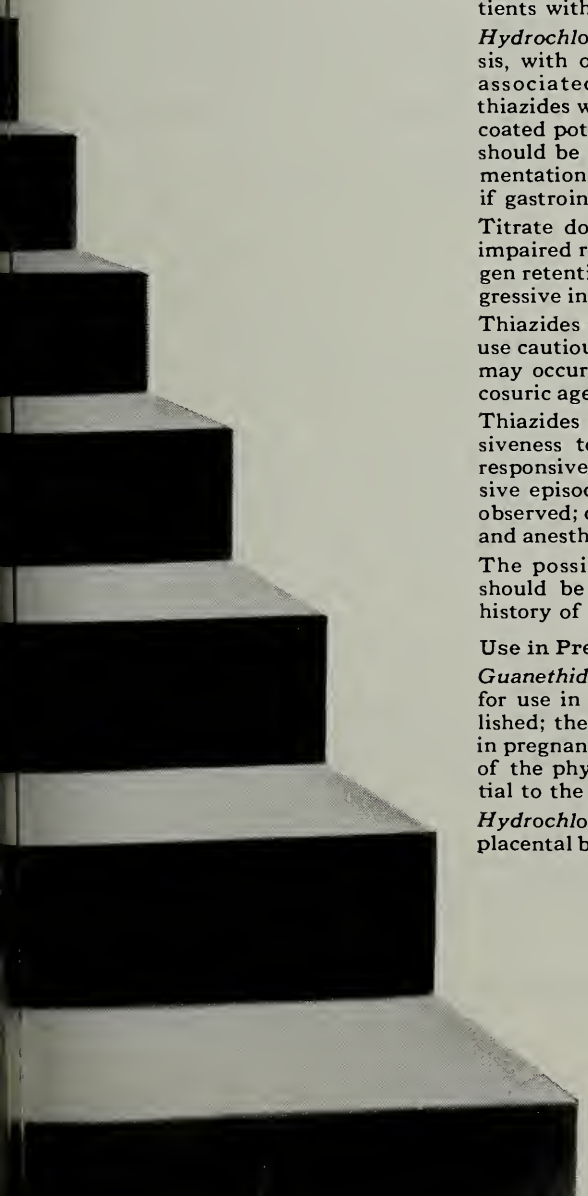


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INDICATIONS

Hypertension which cannot be adequately controlled with simpler agents; moderate to severe hypertension; sustained hypertension; almost all forms of fixed and progressive hypertensive disease; when side effects of other antihypertensives prevent effective treatment.

CONTRAINDICATIONS

Guanethidine: Proven or suspected pheochromocytoma; hypersensitivity to guanethidine. Do not use with MAO inhibitors.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Guanethidine: Orthostatic hypotension may occur early in treatment, on arising, during hot weather, and after alcohol, prolonged standing, or exercise. Caution patient to sit or lie down with the onset of weakness or dizziness.

Concurrent use with rauwolfia derivatives may cause bradycardia, mental depression, and postural hypotension.

Withdraw therapy 2 weeks prior to surgery if possible to reduce hazard of cardiac arrest or arrhythmia. If not, administer preanesthetic agents, anesthetics, and vasopressors cautiously in reduced dosage with oxygen and atropine ready for immediate use.

Febrile illness may reduce dosage requirements.

Due to catecholamine depletion and increased responsiveness to norepinephrine, special care is required when treating patients with a history of bronchial asthma.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Titrate dosage carefully in patients with impaired renal or hepatic function or nitrogen retention; discontinue thiazides if progressive insufficiency is observed.

Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by uricosuric agents.

Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine. Hypotensive episodes under anesthesia have been observed; decrease dosage of preanesthetic and anesthetic agents.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Guanethidine: The safety of guanethidine for use in pregnancy has not been established; therefore, this drug should be used in pregnant patients when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in breast milk. Thus, adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Guanethidine: Give cautiously to patients with severe coronary insufficiency, recent myocardial infarction, or cerebrovascular insufficiency and with extreme caution in those with severe congestive failure. Peptic ulcers and some other chronic disorders may be aggravated by guanethidine.

Appetite suppressants (amphetamines) and mild stimulants (*eg,* ephedrine, methylphenidate) may decrease the hypotensive effect of guanethidine.

Wait one week after discontinuing MAO inhibitors before starting guanethidine.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and nonrigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Guanethidine: Dizziness, weakness, lassitude, syncope, bradycardia, increase in bowel movements, diarrhea, inhibition of ejaculation, fluid retention, edema, congestive heart failure. Less frequently: dyspnea, fatigue, nausea, vomiting, nocturia, urinary incontinence, dermatitis, scalp hair loss, dry mouth, rise in BUN, ptosis of the lids, blurring of vision, parotid tenderness, myalgia, muscle tremor, mental depression, chest pains (angina), chest paresthesias, nasal congestion, weight gain, and asthma in susceptible individuals.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, muscle spasm, weakness, restlessness, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE

Optimal dosage must be determined for each individual. *Note:* 10 mg guanethidine monosulfate present in Esimil is equivalent to 8.4 mg guanethidine sulfate USP (Ismelin®).

SUPPLIED

Tablets (white, scored), each containing 10 mg guanethidine monosulfate and 25 mg hydrochlorothiazide; bottles of 100.

Before starting therapy, consult complete product literature.

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Minnesotan Is Honor Lecturer at UA

The director of the University of Minnesota Unit for Teaching and Research in Internal Medicine, Dr. Cecil James Watson, will deliver the 11th annual Tinsley R. Harrison Lecture at the Medical Center, University of Alabama in Birmingham, on Tuesday, September 17.

Dr. Watson's lecture is entitled "Gold from Dross: The First Century of the Urobilinoids." Students, faculty, staff and all other interested parties are cordially invited to attend his lecture, scheduled at 12 noon in the Veterans Administration Hospital auditorium.

Dr. Watson, who is also a Distinguished Service Professor at the University of Minnesota, is the 11th renowned health scientist to be designated as Tinsley R. Harrison Lecturer since the lectureship was inaugurated in 1958 by a group of Dr. Harrison's former students.

He completed his undergraduate and graduate education at the University of Minnesota, having earned his M.D. degree in 1926 and his Ph.D. in pathology and hematology in 1928. From 1930-32 he was engaged in graduate training in Munich, Germany, studying bile pigment and porphyrin chemistry with Hans Fischer and clinical medicine with Friedrich V. Mueller.

Upon his return to the United States, he joined the University of Minnesota faculty and in 1943 was named head of the Department of Medicine; he served in this capacity until 1966 when he assumed his present position.

85 Matriculate as UMC Frosh

The 14th incoming class of medical students at the University of Mississippi Medical Center began their classwork on Sept. 5.

The 85 new students were selected competitively from some 750 applicants for the School of Medicine Class of 1972, according to Dr. Robert E. Carter, director of the Medical Center and dean of the School of Medicine.

Announced by Dr. L. L. Sulya, chairman of the admissions committee, the class includes 20 from Hinds County. Most of the freshmen did their premedical work at Mississippi institutions, but seven schools in four neighboring states are also represented in the prospective physicians.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
October 1968, Vol. IX, No. 10

ORIGINAL PAPERS

Amenorrhea: An Approach To Diagnosis and Management

JOHN C. WEED, M.D.
New Orleans, Louisiana

AMENORRHEA IS a symptom, not a disease, but a sign of abnormal physiology, of anomalous development or of a troubled environment. It is a symptom welcomed by some as a relief from the curse of womankind, as an indication of a hoped for gestation, or as a respite from malaise; but it is often feared by others as indicative of an unwanted pregnancy or a disturbed physiology as yet unknown. In either instance, the emotional impact may be tremendous. Often, however, amenorrhea occurs insidiously, unrecognized or subconsciously ignored.

The diagnosis of primary amenorrhea indicates that menstrual bleeding has never occurred. In the United States, the average age of menarche is about 12 years, but the appearance of menses in three years in either direction may occur in normal individuals. Consequently, investigation for primary amenorrhea may be delayed until the age of 16 years or more in the belief that such amenorrhea is simply delayed puberty. Syndromes in which primary amenorrhea occur in phenotypic females without secondary sex characteristics are listed in Table 1. Almost half of cases of primary amenorrhea (Jacobs,[1] Behrman[2]) have had abnormal chromosomal component. For this reason, an initial examination of these individuals is the buccal smear preparation for sex chromatin; and later the chromosomal determination from cultured leukocytes.

Typically, the gonadal dysgenesis group are short, pre-pubertal females, many of whom have characteristics of Turner's syndrome, but all of whom are shorter in stature than their siblings and classmates of equal age. The genitalia are those of prepubertal females with a normal vagina, an infantile cervix and uterus. The gonad stimulating hormones (GSH) by bio-assay are elevated, well beyond that of the individual with delayed puberty. These patients with gonadal dysgenesis have streak ovaries showing ovarian stroma without primordial follicles. Sex chromatin is usually absent and the karyotype is XO.

Amenorrhea is a symptom of abnormal physiology, anomalous development or a troubled environment. It may occur insidiously or be unrecognized or subconsciously ignored. The author presents an approach to investigation and management of amenorrhea, both primary and secondary.

Their taller sisters, who seem to have delayed puberty but whose amenorrhea continues beyond a moderate delay until it becomes obvious that menarche will never occur, are those with sex

Read before the 100th Annual Session, Mississippi State Medical Association, Jackson, May 15, 1968.
From the Department of Obstetrics and Gynecology, Tulane University School of Medicine.

chromatin, elevated GSH and normal genitalia, but with unresponsive ovaries. These fall into a class known as hypogonadal eunuchoidism.

A group of phenotypic females with primary amenorrhea and without secondary sex characteristics include testicular feminization and male pseudohermaphrodism. In each the sex chromatin is negative and the karyotype XY. Testicular feminization usually is associated with breast development of varying degree and at the time of initial examination this secondary sex characteristic may not be developed. In each instance, the genitalia assume the female type although the clitoris may be somewhat enlarged. There is a short vaginal tract, but the uterus and cervix cannot be identified. In true hermaphroditism, the sex chromatin may be present or equivocal. True hermaphroditism, requiring both ovarian and testicular components in the gonad, is rarely recognized at this age.

ADRENAL HYPERPLASIA

Neglected congenital adrenal hyperplasia is accompanied by primary amenorrhea. Precocious somatic growth occurs and the patient's mother anticipates menstruation because of pubic hair development, though breast development is conspicuously absent. Investigation is often not sought at this stage, but is requested later because of increased hair growth and the failure for feminine development.

TABLE 1

SYNDROMES WITH PRIMARY AMENORRHEA SECONDARY SEX CHARACTERISTICS ABSENT

Syndrome	*Sex Chromatin*	*Karyotype*	*Comment*
Gonadal dysgenesis			
Turner's syndrome	±	XO, XX-XO	Short stature
Pure type	–	XY	Short stature
Delayed puberty	+	XX	Average stature
Hypogonadism	+	XX, Xx	Tall stature
Testicular feminization	–	XY	Average stature ± Clitoral hypertrophy
Hermaphroditism	±	XY-XX	Average stature ± Clitoral hypertrophy
Congenital adrenal hyperplasia	+	XX	Short stature ± Clitoral hypertrophy

In other girls whose growth has been comparable to siblings or classmates, and secondary sexual characteristics have developed, amenorrhea may be a prominent symptom. In these patients, menstrual molimina may occur with some cyclic changes in the breasts (Table 2).

TABLE 2

OTHER CAUSES OF PRIMARY AMENORRHEA SECONDARY SEX CHARACTERISTICS PRESENT

Physical Findings	*Comment*
Imperforate hymen	Normal genitalia
Absence or stricture of vagina	Normal ovaries (± uterus)
Absence or stricture of vagina with no sex chromatin	Testicular feminization Hypogonadal eunuchoidism
Normal genitalia	
Normal genitalia with hirsutism	Cushing's syndrome Adrenal tumor

It is surprising how often anomalies of the vagina account for primary amenorrhea. The simplest is the imperforate hymen which is easily diagnosed by inspection and rectal examination. In one such patient, reluctance for adequate examination and minimal symptoms led her to accept her amenorrhea for 12 years before hematocolpos and hematometra were drained.

Probing the vaginal canal may indicate a shortened structure, congenitally absent, or strictured above the hymenal opening at some level. Rectal examination may indicate the presence of a uterus, although ovaries are often difficult to palpate. On occasion, the uterus functions normally and retrograde menstruation may occur leading to pelvic endometriosis. When the secondary sex characteristics are normal, the vagina is short or strictured, the sex chromatin is negative, and the chromosome is XY, testicular feminization is indicated. As in the instance of normal sex chromatin and presumably normal ovaries, these patients with testicular feminization have estrogen production to cause satisfactory breast development. Usually, however, axillary and pubic hair are deficient.

HYPOGONADAL EUNUCHOIDISM

Whenever primary sex characteristics are present, although incompletely developed, and the individual is above average in height, hypogonadal eunuchoidism should be suspected. In these the genitalia are normal, they are chromatin positive

and GSH is elevated. There is disproportionate growth of the extremities over the trunk from the failure of epiphyseal closure. In a few instances, secondary sex development may be present with normal genitalia and with increased hair growth. Cushing's syndrome or an adrenal tumor conceivably could be present and differential diagnosis will be discussed later.

The treatment of primary amenorrhea must be individualized. When an amenorrheic prepubertal female shows minimal secondary sex characteristics, has Barr bodies and normal genitalia, the question of delayed puberty versus hypogonadism or a form of gonadal dysgenesis is a real problem. After the 17th birthday, the initiation of normal ovarian function is unlikely, with a normal XX karyotype, and inspection of the ovaries by laparotomy or culdoscopy is desirable. When deficient ovarian tissue is found, and GSH titer is elevated, substitution therapy is desirable.

GONADAL DYSGENESIS

In gonadal dysgenesis substitution therapy must be instituted for growth and development of secondary sex characteristics but with some caution since epiphyseal closure will occur. The administration of estrogens will cause a growth spurt, but at the same time, maturation of the epiphyses will occur, resulting in a short adult. Cyclic administration is desirable, and ultimately growth of the cervix and uterus will occur with estrogen withdrawal bleeding. Accompanying menstruation will be maturation of the emotions and psyche of the individual to adult levels.

In testicular feminization and male pseudohermaphroditism with female phenotype, individualization is also desirable, but in general it is better for the gonads to be removed and ovarian hormone substitution administered with surgical correction of the aplastic or inadequate vagina when the patient is emotionally prepared for this procedure. In hypo-ovarianism and hypogonadism, at present there is no known therapy to initiate ovarian action and, therefore, substitution therapy becomes necessary.

When the menstrual function has been established with regular or fairly regular menstruation, it indicates with reasonable assurance, pituitary stimulation of ovarian function and subsequent endometrial response. The menstrual interval varies from 18 to 42 days in 97 per cent of women with the peak incidence at 28-29 days. Failure to menstruate for four months after an established rhythm constitutes secondary amenorrhea. There are many causes for the failure of menstruation, including physiologic changes, primary ovarian disturbances, ovarian changes secondary to other endocrine abnormalities involving the thyroid, pituitary or adrenal gland, metabolic disturbances and psychogenic states.

In an effort to separate the various etiologic factors the present approach to diagnosis and management of secondary amenorrhea is presented (Table 3).

TABLE 3

CAUSES OF SECONDARY AMENORRHEA
NORMAL FEMALE WITH NO BREAST SECRETION

- I. Pregnancy
- II. Progesterone followed by
 - A. Menses
 - 1. Estrogen producing tumor
 - 2. Stein-Leventhal syndrome
 - 3. Anovulation
 - B. No menses—then cyclic estrogen followed by
 - 1. No menses
 - a. Pregnancy
 - b. Cervical stenosis
 - c. Asherman's syndrome
 - d. Tuberculous endometritis
 - e. Ablation
 - 2. Menses
 - a. Ovarian failure
 - b. Pituitary failure
 - (1) Tumor
 - (2) Sheehan's syndrome
 - c. Hypothalmic disease
 - (1) Anorexia nervosa
 - (2) Estrogen-progestagen contraception
 - (3) Severe debilitating disease

Initial examination should note the period of amenorrhea and the frequency and cyclicity of menses, the presence or absence of breast secretion, loss of breast size and normal or increased hair growth. An estimation of estrogenic stimulation to the vaginal mucous membrane through a maturation index is helpful in indicating the presence or absence of endogenous estrogen production.

In the case of secondary amenorrhea with normal female development and no breast secretion, the possibility of pregnancy in all patients should be considered. Early pregnancy is often masked by complete absence of symptoms and may be difficult to establish by clinical examination. Should there be any suspicion of pregnancy, urinary tests for chorionic gonadotropin are easily available.

ESTROGEN PRODUCTION

In order to establish the presence of endogenous estrogen production, progestogen is administered best by injection of progesterone. If this is followed by menses within seven to ten days, it is apparent that ovarian estrogen produc-

tion is taking place in an uninterrupted fashion either from (a) an estrogen producing tumor, such as granulosa cell or theca cell or from (b) anovulation occurring in the Stein-Leventhal syndrome or in other individuals lacking the stigmata of this syndrome. Anovulation precedes complete ovarian failure of physiologic and premature menopause, with a failure of the estrogen feedback regulation of pituitary function.[3] In each of these states the GHS determination is likely to be normal or only slightly elevated. Resumption of normal menstrual cycles is difficult to achieve in these patients; yet some success has resulted from cyclic progestogen administration, either oral or by injection. The presence of a tumor or bilateral enlargement would indicate corrective surgical management.

In those cases of secondary amenorrhea with no breast secretion, injection of a progestogen which failed to cause progesterone withdrawal bleeding would again suggest the possibility of pregnancy, and tests for chorionic gonadotropin should be instituted. If cyclic estrogen is then administered with no withdrawal bleeding, anatomical factors may interfere with endometrial function or the emission of menstrual flow. These include stricture or stenosis of the cervix, obliteration of the endometrial cavity (Asherman's syndrome), or destruction of the endometrium by tuberculous endometritis. Dilation and curettage and uterosalpingography are helpful in establishing the diagnosis of each of these problems.

FAILURE OF PROGESTOGEN

Where initial progestogen injection has failed to cause menstruation, cyclic estrogen followed by withdrawal bleeding indicates that the uterus remains a receptive organ and endogenous estrogen production has failed, either because of ovarian failure to respond to the pituitary gonadotropin or because of the failure for the pituitary to produce the gonad stimulating hormone. In the first instance, the GSH assay of a 24-hour urine specimen would be moderately to greatly increased and the prognosis for resumption of ovarian activity is poor. Substitution therapy then becomes necessary with the amount of cyclic estrogen administered to keep the patient asymptomatic and withdrawal bleeding to a minimum degree. Pituitary failure may be difficult to establish. Careful inquiry in regard to headaches and visual disturbances should be instituted and x-ray examination of the sella turcica should be performed. Secondary amenorrhea is the initial symptom of pituitary tumor in many instances, and diagnosis can be made only by serial roentgenography of the sella for several years.

HYPOPITUITARISM

Similarly, in the absence of pituitary stimulation, the possibility of hypopituitarism resulting from postpartal pituitary necrosis (Sheehan's syndrome) should be considered. Sheehan's syndrome is often associated with other forms of hypopituitarism, such as myxedema and hypoadrenalism. Pituitary failure by tumor, and the hypopituitarism of Sheehan's syndrome have absent or very low levels of gonad stimulating hormones in the 24-hour urine specimen.

Included in the group of causes of secondary amenorrhea in women with no breast secretion are those poorly understood groups of cases attributed to hypothalamic disease. It has long been understood that the hypothalamus regulates the production of the gonad stimulating hormones and that the hypothalamus is affected by the general welfare of the individual. It is thought that the lack of gonad stimulating hormones resulting from anorexia nervosa, severe debilitating diseases and psychogenic problems result from continuous production of an inhibiting factor in the hypothalamic region.[3] With correction of the debilitating disease, or improvement of the basic psychiatric problem, resumption of normal cyclicity of pituitary gonadotropic hormone production ensues. This may be enhanced by cyclic estrogen administration but prognosis should be guarded. The possibility of prolonged estrogen-progestogen contraception as a cause for subsequent secondary amenorrhea mediated through the hypothalamus is suggested. It has been our observation that patients with oligomenorrhea who have employed estrogen-progestogen contraception for months and then discontinued this contraceptive method may have a secondary amenorrhea which mimics in every respect that associated with anorexia nervosa or that precipitated by a psychiatric problem. This group of individuals causes further confusion by the fact that some have breast secretion.

HYPOMETABOLIC STATES

In all instances of secondary amenorrhea in normal females with no breast secretion, the possibility of hypothyrodism and hypometabolic states should be considered. Myxedema should be recognized by a very low protein bound iodine or other tests of thyroid deficiency. In borderline

instances the administration of empiric doses of thyroid will improve the general metabolic state of the individual, thus aiding in the correction of menstrual disorder.

Possible causes of secondary amenorrhea in the normally developed female, whose breasts secrete a milky fluid are listed in Table 4. The possibility that persistent lactation has occurred following a normal pregnancy and puerperium could be eliminated through history. Intermittent or irregular suckling of the breast may be sufficient to cause persistence of the lactating stimulus with its inhibition of gonadotropic hormone production. Drug-induced lactation also occurs, notably from chlorpromazine and rauwolfia derivatives.[5] The basic problem for which these drugs have been employed probably has had an effect on the hypothalamus also. Again, certain estrogen-progestrogen contraceptive programs have led to breast secretion and persistent secondary amenorrhea when discontinued. The Chiari-Frommel syndrome (amenorrhea, lactating breasts, and subinvolution of the uterus with hypoestrogenic changes in the vaginal mucous membrane) develops subsequent to a pregnancy, either full term or aborted. The Ahumada-Del Castillo syndrome is similar but lacks the previous history of pregnancy. Effective management of these conditions (the Chiari-Frommel, the Del Castillo syndrome and estrogen-progestogen contraception followed by breast secretion) essentially are ineffective. Clomiphene may induce ovulation and subsequent pregnancy in lactation syndromes. However, following such a pregnancy, persistent secondary amenorrhea returns. About one-half of the patients with lactation amenorrhea syndromes ultimately develop pituitary tumors, and x-ray of the sella turcica should be made at intervals to

TABLE 4

CAUSES OF SECONDARY AMENORRHEA
NORMAL FEMALE WITH SECRETING BREASTS

1. Persistent lactation
2. Drug induced
 a. Chlorpromazine
 b. Rauwolffia
 c. Estrogen-progestagen contraception
3. Chiari-Frommel syndrome
 Ahumada-del Caltillo syndrome
4. Pituitary tumors
 a. Acromegaly
 b. Craniopharyngioma

detect early signs of pituitary enlargement. Such pituitary tumors as acromegaly and craniopharyngioma are associated with lactation amenorrhea as a finding incidental to the other more prominent features.

A final group of patients with secondary amenorrhea and without breast secretion are those associated with hirsutism, with or without virilism. In these individuals, normal growth and development has occurred, but progressively, hair growth, amenorrhea and reversal of secondary sex characteristics to masculine phenotypes, such as regression of breasts, loss of secondary fat pads or increased generalized obesity with a buffalo hump, may develop. In these, amenorrhea is a prominent symptom because of the gradual development of hirsutism and changes of fat distribution.

TABLE 5

CAUSES OF SECONDARY AMENORRHEA
WITH HIRSUTISM AND/OR VIRILISM

Hirsutism without defeminization

17 KS normal → Stein-Leventhal syndrome
17 OH normal
17 OH elevated → Cushing's syndrome

Hirsutism with defeminization

17 KS elevated
followed by
17 OH normal

Adrenal suppression	17 KS ↓	Adrenal hyperplasia
Adrenal suppression	17 KS –	Adrenal tumor
Adrenal suppression	17 KS ±	Virilizing ovarian tumor

HIRSUTISM

Where hirsutism is present, 17-ketosteroid and 17-hydroxysteroid determinations from 24-hour urine collections should be performed. If hirsutism is a prominent feature without defeminization, the Stein-Leventhal syndrome should be suspected and the ovaries should be visualized by Pneumogynography or inspected at laparotomy. Excretion of 17-ketosteroid is apt to be variable and those individuals may exhibit high levels within the normal range of any particular laboratory. When the 17-hydroxycorticoids are elevated, Cushing's syndrome is present and requires appropriate treatment. The Stein-Leventhal syndrome is best treated by wedge resection of the ovaries which carries the highest percentage of permanent relief. However, Clomiphene is widely used for the induction of ovulation in these individuals with subsequent pregnancy but reversion to the former state will occur.

Hirsutism with defeminization is associated with elevated 17-ketosteroids from moderate to extreme degree. When such a patient with an ele-

vated 17-ketosteroid is followed by adrenal suppression by Dexamethasone, reduction of 17-ketosteroids indicates that the adrenal is the source of this abnormal ketosteroid production and that adrenal hyperplasia exists. Correction of this abnormal problem by the administration of adrenal corticoids will allow the resumption of normal menstrual activity and, in some instances, successful pregnancies. If adrenal suppression shows no reduction of elevated 17-ketosteroid excretion, the presence of adrenal tumor should be suspected and its presence sought by exploratory surgery. Removal of such a tumor would cause the return of menstrual function and fertility.

Adrenal suppression without any ovarian production of 17-ketosteroids should reduce the 17-ketosteroids to virtually zero. If there is a partial decrease in 17-ketosteroids or no change in the slightly elevated 17-ketosteroid excretion, the possibility of a virilizing ovarian tumor should be considered. Such tumors may be small but functional to the degree of causing amenorrhea and hirsutism, and after elimination of adrenal hyperplasia or adrenal tumors as the cause of the elevation of 17-ketosteroids with defeminization and hirsutism, exploratory laparotomy is justified.

The size of the clitoris in these individuals is not of great assistance in establishing the diagnosis since hypertrophy would occur only if the process is outstanding.

SUMMARY

An approach to investigation and management of amenorrhea, both primary and secondary, has been presented indicating the necessity of examining the patients with primary amenorrhea with buccal smears and chromosomal studies when the etiology is not easily demonstrated. In cases of gonadal dysgenesis, cyclic estrogen replacement will lead to maturation of secondary sex characteristics and a useful place in society. In testicular feminization and male pseudohemophroditism, gonadectomy, with replacement of estrogen is desirable in many instances. In primary hypogonadism, cyclic steroid administration is desirable.

SECONDARY AMENORRHEA

A program for investigation of secondary amenorrhea is presented with means of differentiating various types and causes of symptoms. Complete laboratory examination is necessary with gonad stimulating hormone determinations in many instances, as well as 17-ketosteroid and 17-hydroxycorticoid excretion studies. The possibility of pituitary tumors as a cause of secondary amenorrhea should alert the physician to seek early detection of pituitary tumor. An awareness of the possibility of amenorrhea as a result of estrogen-progesterone contraceptive programs should lead to some caution in prescribing this form of contraception for patients with an already poorly functioning menstrual system. ★★★

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SIDE EFFECT

A drug is a substance which, if injected into an animal, produces a paper.

—Otto Loewi, Ph.D., *quoted in IBM Think*

Clinicopathological Conference XC

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The patient in CPC XC is a 3-year-old white male admitted with severe diarrhea which had started about 36 hours previously. Discussers are Dr. Cecil G. Jenkins and Dr. William B. Wilson.

THIS 3-YEAR-OLD white male was brought to the emergency room moribund, with severe diarrhea. This had started about 36 hours previously, not as an explosive diarrhea, but as increasingly frequent and watery stools. His mother initially did not think he was very ill, but he had many bowel movements during the night, and the next morning (about 24 hours after the onset of the diarrhea) he was found to have high fever and rapid respirations. He was hospitalized at his local hospital, where the exact therapy he received is not known. However, he soon became disoriented, cyanotic, and increasingly hyperpneic. Fluids and oxygen were started, and he was transferred to Baptist Hospital that afternoon. There is no recorded history of vomiting or of blood in the stools.

The patient was the product of a normal pregnancy and had been well all his life until the present illness. There was no history of ingestion of aspirin or known toxins. There had been no recent illness in the family. There was no family history of diabetes. The family lived on a farm.

On examination here the temperature was 100.2° (R), pulse 150, respiration 28, and blood pressure was unobtainable. The child was critically ill, comatose, and in extensor rigidity. Pupils reacted sluggishly to light. The oropharynx and ears were negative. The neck was supple. Coarse rhonchi were heard throughout the lungs. No heart murmurs were heard. The abdomen was distended, but soft, and no organs or masses were felt. The fingers and toes were cyanotic. The peripheral pulses were not palpable. Reflexes were absent. A moderate-sized stool was passed, which was watery, brown, and admixed with much green mucus. No laboratory examination of the stool was made.

Admission lab work showed hemoglobin of 12.8 gm. per cent, hematocrit 38 per cent, and white count 6,300, with 13 per cent monocytes, 52 per cent lumphocytes, 2 per cent segs, 20 per cent bands, 5 per cent myelocytes, 8 per cent metamyelocytes, and an occasional nucleated red cell. Urine showed 2+ protein and trace glucose (intravenous fluids running), trace acetone, pH 5, specific gravity 1.013, and occasional white and red blood cells. After an indwelling catheter was put in, the urine was described as "red." Urine salicylate was negative. Blood glucose was 300 mg. per cent (fluids running), and BUN 50 mg. per cent. Chloride was 94, CO_2 9.5, potassium 7.6, and sodium 125 mEq./L. Blood salicylate was 2.25 mg. per cent and pH 7.24.

Sodium bicarbonate and calcium gluconate were given intravenously, and the blood pH rose to 7.41. Ampicillin was given intravenously. Oxygen under positive pressure was continued. One hour after admission the blood pressure rose to 75/60. It then again became unobtainable but subsequently rose again to 70/60. The rectal temperature was recorded four hours after admission as 104.4°. The respirations gradually rose to 36/minute, and the pulse remained around 140-160. The patient remained in extensor rigidity with occasional extensor spasms and expired six hours after admission.

Dr. Cecil G. Jenkins: "This is a case of a 3-year-old child who was in good health until the onset of diarrhea 24 hours before hospitalization. The diarrhea started one morning and became increasingly more severe through the day and night. The next morning he was admitted to a local hospital, where he soon became disoriented,

From the Department of Pathology, Mississippi Baptist Hospital.

cyanotic, and increasingly hyperpneic. He was then transferred to the Baptist Hospital, and the history tells us there was no history of vomiting, or blood in the bowel movements. Apparently, this child had been well all through his life, and in view of the acidosis, history was taken as to ingestion of aspirin or other toxins, and this was negative. Also, it is commented that there were no recent illnesses in other members of the family, and no family history of diabetes. He also lived on a farm.

"The examination when the child arrived here showed the temperature of 100.2° rectally, pulse of 150, respirations at 28, and unobtainable blood pressure. Obviously, this child was critically ill, comatose, and is described at this time as being in extensor rigidity. We don't know when this started, or whether or not this was present at the local hospital. The pupils did react very sluggishly to light. Nose and throat were negative; neck supple. Coarse rhonchi were heard throughout the lungs, which really is not surprising in a child who is comatose and is hyperpneic. He was cyanotic. The peripheral pulses were not palpable; reflexes absent; and he passed a semi-liquid, brown stool with green mucus.

LABORATORY FINDINGS

"The admission laboratory work showed a 12.8 gm. per cent hemoglobin, with hematocrit of 38 per cent, and a white count of only 6,300 of which 13 per cent were monocytes, 52 per cent lymphocytes, only 2 per cent segs, 20 per cent bands, and then we had some very early forms, 5 per cent myelocytes and 8 per cent metamyelocytes, with some occasional nucleated red cells. The urine showed a 2+ protein with a trace of glucose and trace of acetone, pH of 5, specific gravity of 1.013, and only occasional white or red blood cells.

"After an indwelling catheter was put in, the urine was described as 'red,' and I don't know what that means. The urine salicylate was negative. Apparently, with this markedly hyperpneic child the thought of aspirin intoxication came to mind. This was rapidly ruled out by getting a urine salicylate level, and was further excluded by a blood salicylate of only 2.25 mg. per cent. The blood glucose was 300 mg. per cent, which isn't outrageously high with an IV going.

"The chemistries showed a chloride of 94 and CO_2 of 9.5, potassium of 7.6, sodium of 125 mEq./L., and a blood pH of 7.24, verifying the fact that we are dealing with a metabolic acidosis. This child was severely acidotic, as indicated by the marked depression of blood CO_2 and pH; yet the blood sugar was only moderately elevated and the urine showed only a trace of sugar and acetone. I think this combination lets us rule out diabetes as a cause for the severe acidosis.

TREATMENT REGIMEN

"The treatment consisted of sodium bicarbonate and calcium gluconate intravenously. I'm not sure whether somebody knew something we don't know as to why this calcium gluconate was given, or maybe this was just being given empirically to prevent some hypocalcemia when this acidosis was corrected. Ampicillin was started intravenously. Oxygen was given. There was some slight response, but the temperature rose to 104, respirations increased to 36, and during the course of the next six hours the child progressively got worse and died.

"So, essentially, we've got several severe problems, the primary one being acidosis. Two of the most prevalent problems that present with children with marked acidosis, aspirin intoxication and diabetic coma, I think we pretty well ruled out on the basis of the findings described before. Probably the most common cause of acidosis in children is diarrhea, which fits this case beautifully. Poisonings also can do this. We know that a 3-year-old child is adept at getting into things that he should not be getting into. Though the history says there were no known toxin ingestions, the 3-year-old can be rather good at getting into things and not being caught, so we still have to consider this.

"We have to consider the various infectious causes of diarrhea. The viruses are the most common; however, viral diarrhea usually is not nearly so marked as this, certainly not this fulminating, and the illness generally does not follow this course at all. So, just on the basis of that, I would not consider viral diarrhea very strongly. Staphylococcal food poisoning can be this fulminating; however, assuming this child ate the same thing that the other members of the family did and none of them were reported ill, we will, on this evidence, discard that.

FULMINATING DISEASE

"Typhoid fever occasionally may present with a fulminating diarrhea, and certainly we've got a lot of toxicity; we've got the low white count; we've got the critically sick child with a ful-

minating disease. Now, just on the basis of frequency of presentation, I would not consider typhoid as being the most likely form of infection for this child. The other two types of infection, the Salmonella and Shigella, I would lump together because, I think, primarily this is a laboratory differentiation. Both of these cause a fulminating, febrile type of gastroenteritis, and they often are associated with extreme toxemia, and so I would think, of the infections, one of these two types would be highly likely.

"Returning to the poisons, we would have to consider the insecticides. This child did live on a farm. One of the common products in an insecticide is fluoride, and a fluoride intoxication can produce gastroenteritis, diarrhea, dehydration, shock, tetany, acidosis, and renal injury. In fact, it could easily present the picture that we have here. On the basis of the information we have here, we cannot be sure the extensor rigidity might not be hypocalcemic tetany, but if it were, an intoxication with an insecticide, especially one containing fluoride, would have to be considered as a cause of hypocalcemia and, therefore, tetany.

"We could go on to the other symptoms; however, I think we would still come down to the infection, with the associated toxemia, versus the poison, and on the basis of the age group, the fulminating course of it, and the relative frequency, I would have to say that I would think this child had a bacillary dysentery, with overwhelming infection, with shigellosis."

AUTOPSY FINDINGS

Dr. William B. Wilson: "When the body was put on the autopsy table, a blob of pale green mucus issued from the rectum, which was fairly characteristic-looking for shigellosis. On examination of the colon, the mucosa of the rectum was found to be fiery-red, edematous, swollen, and diffusely, superficially ulcerated, with flecks of thick mucus on the surface. The inflammation decreased as one looked higher up the sigmoid, and the distal half of the colon was mainly involved.

"This is a low-powered microscopic view of the colon. Essentially, it shows a fairly superficial ulceration of the mucosa, with diffuse, granulocytic infiltration of the mucosa, not extending below the muscularis mucosae, although there is edema, congestion and mild inflammatory infiltration of the submucosa. The inflammatory process in the mucosa is acute and necrotizing. The exudate is composed primarily of polymorphonuclear leukocytes, with a necrotic layer overlying the ulcerated mucosa.

"Here is a high power view of the mucosa, demonstrating the polymorphonuclear leukocytic character of the infiltrate. This extremely acute, necrotizing, superficial inflammation of the colon mucosa is characteristic of Shigella infection, in contrast to the blander inflammations of viral, amebic, and salmonella colitis, and the deep ulcerations of amebic colitis, chronic non-specific ulcerative colitis, and granulomatous colitis.

COLON CULTURE

"I was hoping to demonstrate large numbers of very small, rod-shaped bacteria in this Giemsa-stained, oil-immersion photomicrograph of the colon mucosa, but I'm afraid this slide is not going to show these bacteria up very well. Here's one here, and some more here. Actually, they were scattered very heavily throughout this exudate, small, rod-shaped bacteria about half the size of the usual coliform bacteria. Culture of the colon and also the ileum showed a pure growth of *Shigella sonnei,* sensitive to chloramphenicol and tetracycline, but not to ampicillin.

"The brain showed intense cerebral edema. The lateral ventricles were almost completely compressed. There was not an actual herniation of the cerebellar tonsils, although they were compressed by the general swelling. The meninges showed no exudate, and microscopic examination showed no evidence of meningitis or encephalitis. The neurons showed anoxic changes. The kidney tubules and the liver showed nonspecific changes of cloudy swelling, which would go along with the shock and fever.

"Summertime is when bacterial diarrhea is most common. We all are aware of the old days when hospital wards were full of typhoid and bacillary dysentery in the summer, and the fulminating, fatal course in this child serves to remind us that the aged and the very young are primarily the ones who die of bacillary dysentery. The early diagnosis, before cultures can be reported, can be inferred on the basis of the high polymorphonuclear leukocytic content of the stool and associated mucus, as visualized with methylene blue, Wright's or Gram stains.

GRAM-POSITIVE COCCI

"The other type of severe diarrhea which has a high polymorphonuclear leukocytic infiltrate in the stool is staphylococcal, but in that case Gram stain of the stool shows gram-positive cocci. These should be present in huge numbers to be

diagnostic. Viral and salmonella gastroenteritis, and amebic colitis, have a blander exudate with a large proportion of mononuclear cells. So, a high polymorphonuclear leukocytic content in the stool smear, without gram-positive cocci in huge numbers, is characteristic of shigellosis. Another important diagnostic point, illustrated in this case, is the very large amount of mucus in the stool. The antibiotics of choice in shigellosis are chloramphenicol and tetracycline.

"Shigellosis in this country is usually due to *S. sonnei;* it appears sporadically and usually not in epidemics. There is no animal reservoir for Shigella, and the organisms are transmitted only from human to human, primarily by family contact, flies, and fecally contaminated fomites, such as toilet seats. Poor sanitary conditions facilitate the spread, but waterborne transmission is not important. This is in contrast to the epidemiology of Salmonella and amebic diarrhea. Staphylococcal gastroenteritis is almost always caused by eating unrefrigerated food in which incidental staphylococci have had an opportunity to multiply, and therefore several people usually become ill simultaneously, giving an important diagnostic clue, as Dr. Jenkins pointed out."

Dr. Jenkins: "What about the markedly decreased number of segmented neutrophils on the smear?"

Dr. Wilson: "The white count is normal in Shigella diarrhea, probably in part because Shigella does not invade the blood stream. Actually, elevated white count is not characteristic of viral or Salmonella acute gastroenteritis (which is not to be confused with Salmonella enteric fever, which has a different pathogenesis). Immature granulocytes and nucleated red cells on the peripheral smear are not uncommonly seen in acutely ill patients, especially those in hypovolemic shock. I agree that the shift to the left in this case was unusually marked." ★★★

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NO-ROSES

The mother had her young daughter at the beach for an afternoon outing. "Get away from the water, Mary," shouted the mother. "It's too cold."

A few moments later: "Don't play in the sand, Mary, it's too damp."

The child asked for a popsicle, and the mother replied, "No, indeed not, it's too fattening."

Persisting, Mary asked for a ham sandwich. "No," was the response. "It will spoil your dinner."

Turning to a friend with whom she had been chatting, the mother noted: "Did you ever see such a neurotic child?"

Profile of Attainment—Measure of Need, Part IV

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

SINCE 1964, three major studies relating in part or whole to the general area of medical education with special emphasis on postgraduate education have been published. The first of these was the Report of the President's Commission on Heart Disease, Cancer, and Stroke, published in 1964. The commission's report contained the blueprint for the Regional Medical Programs which were brought into being by an act of the Congress in 1965.

The second study was entitled "Planning for Medical Progress Through Education," a substantial work by Dr. Lowell T. Coggeshall under the sponsorship of the Association of American Medical Colleges. The third, the Report of the Citizens Commission on Graduate Medical Education, is popularly called the Millis Report, because the commission's distinguished chairman was Dr. John S. Millis, president of Western Reserve University. It was published in 1966.

The literature is replete with dozens of other studies in this general area, and one of the most pertinent and valuable such works is the annual report on Medical Education in the United States prepared and published by the Council on Medical Education of the American Medical Association. Each report, study, and publication to which reference has been made makes a strong case for postgraduate medical education and the urgent need for its improvement.

While his study centers almost exclusively on the institution of medical education and the role and function of the Association of American Medical Colleges, as appropriately intended, Dr. Coggeshall examines medical education in an historic perspective, reviews scientific advances, the demand and trends in consumption of medical care, the knowledge explosion, the health manpower problem, and a host of related areas.

As with the Millis Commission a year later, Dr. Coggeshall regards the earning of the undifferentiated M.D. degree as the midpoint in medical education, and he logically advocated that the whole of the process should be viewed as a continuun. Of this, he says:

> "There is growing realization that it is unrealistic to assume that effectively articulated education, progressing in logical sequence from the rudiments to mastery, can be provided through fragmented programs under different jurisdictions. A most significant implication of emerging trends is that medical education should, in the future, be planned and provided as a continuum—a continuous process with all elements carefully integrated and under coordinated leadership."

This portion of the series on the study of postgraduate medical education in Mississippi, examines in detail other studies of major national importance. The first of these was the Report of the President's Commission on Heart Disease, Cancer, and Stroke, published in 1964. The second was entitled "Planning for Medical Progress Through Education," a work by Dr. Lowell T. Coggeshall under the sponsorship of the Association of American Medical Colleges. The third study, The Report of the Citizens Commission on Graduate Medical Education is popularly called the Millis Report in honor of the chairman, Dr. John S. Millis.

Chairman, Council on Medical Education and member, Board of Trustees, Mississippi State Medical Association.

Adapted from the study report approved by the House of Delegates, 100th Annual Session, May 13-16, 1968.

A strong case for assumption of responsibility by the university center in all aspects of medical education is made on the bases that only the university can mobilize integrated programs of instruction and research. It alone, continues Dr. Coggeshall, comprises all the fields of knowledge and disciplines related to health, so it therefore possesses the unique capacity to encompass all the education required for the health fields. He emphasizes:

> "It is clear that establishing the university as the effective center of medical education is the greatest need and the most important challenge to the field of medical education today. Now, and in the years ahead, the effort must be made to carry this development beyond the developments envisioned by Flexner."

In October 1965, the President signed Public Law 89-239, the Heart Disease, Cancer, and Stroke Amendments to the Public Health Service Act, authorizing grants to assist in the establishment of Regional Medical Programs. To accomplish its purpose, the program seeks a direct and continuous link between the patient, his physician, his community hospital, and the nation's centers of scientific and academic medicine. The law states as its essential nature "to afford to the medical profession and the medical institutions of the nation the opportunity of making available to their patients the latest advances in diagnosis and treatment. . . ."

REGIONAL MEDICAL PROGRAMS

Although two and one-half years have passed since enactment of the law, the Regional Medical Programs are in the formative stages, and this offers an index to the magnitude and full implications envisioned. Each program must have a regional advisory body, because to the extent that it best meets the needs and aspirations of its geographic area, a Regional Medical Program is local in character. As planning phases move into active programs, RMP has placed heavy emphasis on training and demonstration. Inherent in this concept is continuing postgraduate education for physicians.

In the report to the President and the Congress on June 30, 1967, the surgeon general of the United States reported 51 regions from among which 47, including Mississippi, had received planning grants. From among 1,634 members of the respective regional advisory bodies, 356 or more than one out of five, were *practicing* physicians, the largest single classification. Medical school and center officials numbered 281; members of the public, 260; voluntary health agency representatives, 196; hospital administrators, 170; other health personnel, 142; public health officials, 122; and all others, 107.

RMP SPONSORSHIP

Although Public Law 89-239 does not require sponsorship or program direction by a university, these centers are headquarters for 28 of the 47 funded Regional Medical Programs. Nonprofit agencies headquarter 17 among which are five medical societies, 10 newly organized agencies, and two others. Two state (government) and interstate agencies headquarter the two remaining programs. The Mississippi Regional Medical Program is headquartered and coordinated at the University Medical Center.

The geographic area of the Mississippi region is the state itself, and the estimated population encompassed by the program is 2,320,000. The effective beginning date of the Mississippi program was July 1, 1967, with a program approved initially for two years. The first grant was $322,845, and its recommended support for the second year is slightly under $300,000. Dr. Guy D. Campbell of the University Medical Center is program coordinator. As evidence of its interest and concern in postgraduate medical education, the Mississippi Regional Medical Program is assisting this study by funding in part and supplying the data on the UMC postgraduate programs which now exist.

In August 1966, the Citizens Commission on Graduate Medical Education published its report. The commission represents an external view of graduate medical education, and its work is already being compared with that of Abraham Flexner. The commission was sponsored and financed by the American Medical Association, but its report was simultaneously released to the press, universities, hospitals, and medical societies. A majority of the commission's membership came from outside the medical profession, ranging from distinguished educators to industrialists to a former member of the United States Supreme Court. The commission, interestingly enough, did not employ a staff and worked as a committee of the whole.

Three general objectives were sought in the work of the Millis Commission:

—A determination of the various kinds of medical careers necessary to provide society with

medical services of a quality limited only by available medical knowledge.

—A definition of the general and specific characteristics of educational programs which will most effectively provide medical school graduates with the competencies necessary for these professional careers. This should present the ideal design of graduate educational programs in medicine.

—A proposal for modifying or otherwise altering existing programs so that they may approach or attain the ideal as quickly as possible.

The commissioners examined all levels of medical education, and the report reflects extensive use of massive bodies of data. The commission takes a more localized view of the organization of medical education than does Dr. Coggeshall, even recommending that each medical school faculty and each teaching hospital staff explicitly formulate and periodically revise their own educational goals and curricula.

The commission believes that medical schools and teaching hospitals should prepare many more physicians than now exist who will have the desire and the qualifications to render comprehensive, continuing health services. A second recommendation, recognizing that no physician can possibly possess all medical knowledge and that such implies division of specialization, states the patient is undivided and that programs of postgraduate medical education should therefore give greater emphasis to the training of physicians for co-operative effort—among medical specialists and with members of other health professions—in order that each patient may be provided with the combination of skills and knowledge best adapted to his particular needs.

MILLIS ON PG EDUCATION

Organizational goals suggested by the Millis Commission first call for stronger, more centralized, and better coordinated procedures and agencies than now exist for systematic, continuing review and improvement of graduate medical education. Second, the commission feels that in the determination of educational policies and the establishment of programs and standards, the amount of attention given to the needs of medicine as an integrated scientific and professional whole should be greatly increased.

The Millis Report concedes that the general practitioner is vanishing. While there are no totally satisfactory statistics on this discipline, the report notes that in 1931, about 84 per cent of all physicians in private practice classified themselves as general practitioners. In 1960, it was 45 per cent, and in 1965, 37 per cent. Today, at least one out of six general practitioners are over 65 years of age, and some surveys show that only about 15 per cent of current medical school graduates plan to enter general practice. The commission concludes:

> "The general practitioner leaves behind him a vacuum that organized medicine has not decided how to fill."

FAMILY PRACTICE GOALS

But if this assertion were true in August 1966, the mood of American medicine changed with the approval of the recommendations of the Ad Hoc Committee on Education for Family Practice at the November 1966 AMA clinical convention. These two facts underscore the importance of new and adequate postgraduate training for family or primary physicians.

The Millis Commission notes that in some fields of learning, citing as examples history or physics, the members enjoy the privilege of setting their own standards and of determining who is qualified for admission to their guild. Thus, with the judgment of peers alone establishing standards and controlling admission, external and legal controls are considered neither appropriate nor necessary. With the practicing professions, however, members are not thus free, because their endeavors relate to and affect health, property, justice, and other socially vital aspects of life. While such professions, medicine and the law, for example, do suggest their own standards, these are under governmentally effected controls. The point is the variation of standards in medicine:

—Admission to a medical school is under control of the school.

—Admission to practice is under the several states.

—Approval of an internship program is under AMA.

—Approval of a residency program is a combination of AMA and specialty societies and specialty boards.

—Admission to an internship or residency position is at the discretion of the teaching institution.

—Certification by an American board is granted by members of the specialty.

—Who may practice and use the facilities of a hospital is determined by the trustees based on recommendation of the medical staff.

In making a case for reduction of fragmentation in postgraduate medical education, the Millis

Commission recommended creation of a Commission on Graduate Medical Education by AMA.

While clearly qualifying its posture on the role of the university center by stating that "graduate medical education cannot and should not, now or in the foreseeable future, become entirely a university responsibility," the Millis Commission says that "university medical centers should be among pioneers in establishing the facilities for teaching comprehensive and continuous medical care" and for initiating new programs.

In 1967, a new and formal program of accreditation for continuing medical education was initiated, the result of 12 years' effort to build an effective voluntary mechanism. Its objective is to bring the level of quality in continuing programs for the profession to that of basic medical education and formal postgraduate programs of internship and residency training.

The AMA Council on Medical Education believes that the accreditation program will be beneficial in offering guides and standards for sponsoring institutions, in causing—through periodic survey—each institution to examine its own activities and performance, in providing consultation and advice to institutions, in assuring practicing physicians planning their continuing education of receiving instruction and course content of good quality, and in removing from the educational scene those programs which, failing to measure up, are not accordingly improved.

The 13th Annual Listing of Continuing Education Courses for Physicians covering the period September 1, 1967, through August 31, 1968, reflects this new accreditation program reflecting approval of 14 institutions among those in the first survey.

This new accreditation program makes it imperative that continuing education programs organized in Mississippi conform fully with these new and important quality standards. ★★★

2500 N. State St. (39316)

This study was assisted in part by the Regional Medical Program of the University Medical Center, Jackson.

LIFE AT HARD LABOR

The judge was noted for his liberal, modern views. As he sentenced the convicted defendant, he said: "I am going to give you the maximum punishment. I am not going to put you in a nice comfortable jail where your food, shelter, clothing, and medical care are provided by the state. Instead, I hereby free you to go out and contend with rising taxes, high prices, riots, atom bombs, and crazy politics—just like the rest of us."



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



Radiologic Seminar LXXVIII: Non-Osteogenic Fibroma

PHIL O. NELSON, M.D.
Laurel, Mississippi

NON-OSTEOGENIC FIBROMA is a rather common lesion involving both medullary and cortical tissues of bone. It is a focal area of deossification replaced by collagenous fibrous tissue and technically should not be classified as a neoplasm even though it is frequently discussed under the heading of benign neoplasms. It is difficult to estimate the incidence as more than half of the known cases have been symptomless and discovered only on skeletal surveys done for other reasons.

This lesion has a predilection for bone of late childhood, adolescence and early adult life and lesions are frequently multiple. When they are symptomatic, pain is the common complaint, and it is usually of weeks or months' duration suggesting that it is not usually severe. These lesions are more commonly near the end of the diaphysis of long bones and particularly of the lower extremities.

Over a period of months, non-osteogenic fibroma usually enlarges and frequently attains a size of five centimeters. Because of its slow growth, the periosteum is able to lay down a thin



Figure 1



Figure 2

Figures 1 and 2. A radiolucent defect with lobular, sclerotic borders which are sharply outlined is demonstrated in the upper femur. This proved to be non-osteogenic fibroma.

shell of bone over its exterior producing a cortical expansion, and the cancellous tissue at the inner margin undergoes sclerosis. This frequently weakens the bone and occasionally these patients will present with fractures through such lesions.

Because of the characteristic x-ray appearance of these lesions, a diagnostic biopsy is usually unnecessary. From the evidence currently available, the non-osteogenic fibroma can be expected to disappear in two to five years from the time it is diagnosed. Occasionally because of pain or because of a fracture through these lesions, surgical intervention may be necessary and usually takes the form of a curettage and bone chip packing.

★★★

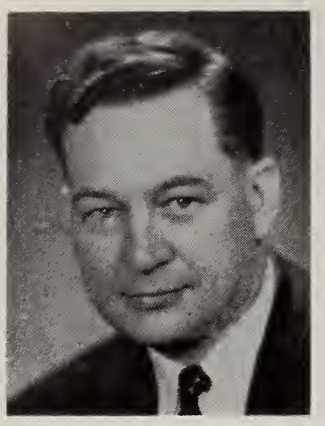
Jones County Community Hospital (39440)

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HAPPY HOUR

The role of a parent is very difficult and perplexing at times. For example, try explaining to a youngster why an ice cream soda will spoil her dinner, while a martini gives you an appetite.



The President Speaking

'A Major Task'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

THE FULL RESOURCES of the Mississippi State Medical Association have long been committed to the development and enactment of a sound, medically-oriented Title XIX program. This is closer to reality than ever before, because we have joined in an active partnership with the State of Mississippi to realize this goal.

At its recent regular meeting, the Board of Trustees approved the association's making a major study for the state which will hopefully be a working baseline for comprehensive health planning and development of a Title XIX program. The association has entered into an agreement with the Office of the Governor to examine almost every facet of health care available in Mississippi and to present our findings and recommendations through the Director of Comprehensive Health Planning, Dr. Alton B. Cobb, in early 1969.

Our study will be guided by a special advisory committee which will be broadly representative of both the specialty disciplines and general practice as well as association leadership. We intend for our investigations and inquiries to have breadth and depth, and by sifting every pertinent item of information so discovered, we will refine and condense our conclusions, making appropriate recommendations within the framework of policy which has guided our efforts.

We are well aware of the magnitude of the task and particularly of the responsibilities which we assume in undertaking it. We are also grateful to our Governor and his associates for the confidence which they have reposed in our association in asking us to make this study. Within a month, a full report of this important project will be made to the membership. In making this first announcement, we are asking your support and counsel of all physicians in this new and useful partnership with our state. ★★★

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EDITORIALS

The Physician and Athletics

RICHARD J. FIELD, JR., M.D.
Centreville, Mississippi

I

THE AMAZING INCREASE in interest in sports in the United States is obvious to everyone. Today, the most popular people in America are not the politicians, the educators, the lawyers, or the doctors, but the athletes. Teen-agers immediately recognize such names as Bart Starr and Gayle Sayer and know much more about them than the Presidential candidates. This trend is heartening in some ways in that it is desirable for people to be strong and healthy, but its resemblance to the decadent Roman Empire is sometimes disconcerting. Nevertheless, competitive athletics is a growing part of the U.S. way of life, and it is important for physicians to recognize this and direct their interest toward the prevention and treatment of athletic injury.

There has been a marked increase in athletic fatalities, particularly in football, since 1964. Prior to this time, there were only 15 cases recorded due to athletics; but, in 1964, there were 29 deaths, and, in 1965, 49 deaths were reported. These deaths were divided into the indirect type, which includes heat strokes, heart stress, and conditions which were indirectly associated with the game. The direct injuries were obvious; most of them involved the head and neck. In 1965, 24 of the cases were the indirect type and 25 were of the direct type.

II

The Trauma Committee of the Mississippi Chapter of the American College of Surgeons has, since 1958, conducted annually, Athletic Injury Seminars throughout the state. The committee has found the athletic personnel of Mississippi high schools and colleges to be most receptive to any help the medical profession can give them in the problem of athletic injury prevention. These clinics have been well attended, and the committee has been gratified at the response to them. Unfortunately, the biggest problem has been with the medical profession. Repeatedly, committee members have been told throughout the state that the physicians have not shown enough interest in their community athletics unless, of course, one of the athletes becomes injured and needs treatment. The committee has endeavored to have a physician on the bench at every contact athletic event in the state. However, the coaches have had difficulty

Regional Chairman, Trauma Committee, American College of Surgeons.

in obtaining a physician in some communities; thus, this editorial.

Physicians should take an active interest in the athletic programs of the schools in their communities, whenever possible. This should include rapport with the coaches as well as the players themselves. Every athlete should be examined prior to the season, and if possible, practice sessions should be observed to check their progress. At the time of this writing, there have been two deaths reported in the United States from heat stroke. This is an entirely preventable problem, and if athletic teams are carefully instructed and observed and a few rules regarding humidity, heat, salt, and water intake are followed, it can be prevented.

III

It is important for the team physician to be on the bench during football games as this gives him the opportunity to observe the occurrence of an injury, which will greatly aid his diagnosis. His presence there is appreciated by the coaching staff. Frequently, by being in this location, the physician can give immediate aid and in an occasional instance, save a life. Occasionally, an athlete in a contact sport will swallow his tongue, and if the physician is in attendance, he can prevent death from suffocation.

The immediate appraisal of head injuries is another important aspect of "on the bench treatment." Frequently, coaches are unsure as to whether injured athletes should continue in play. The presence of a physician on the bench has a great psychological effect on the parents of the participating athletes. They feel much less anxious knowing that a physician is in immediate attendance, and this has been repeatedly expressed over the years.

Finally, the active interest of a physician in the sports programs of his community can be a most satisfying area of his practice. The opportunity to work with the athletes and share with them their victories and defeats is a real one. If you are not actively participating in your community athletics, the committee hopes you will seek out your coach, befriend him, become familiar with his problems, and assist him in building stronger and better citizens for the state. ★★★

Field Clinic (39631)

Ole Miss Is for the Birds!

Ole Miss is for the birds, and it has a $200,000 federal grant to prove it.

At the Oxford campus, the department of psychology is engaged in a science-fiction-like research project for the Department of Defense which has profound biological, if not medical, implications. Dr. W. F. Crowder and his colleagues are studying the possibility of training birds to carry out reconnaissance and bombardment missions such as patroling for submarines or even attacking fixed and mobile enemy targets.

Dr. Crowder was quoted as stating that the defense project hopes to develop means and methods through which "animal-machine systems" can perform selected (military) control functions as well as or far better than human beings. The research would have birds carrying sophisticated and obviously light-weight radio equipment which could trigger weapons systems or gather intelligence.

The present research is a feasibility study to determine whether the Department of Defense should launch into an operational program of bird-operated weapons systems. At present, Ole Miss isn't sending out any bombing missions.



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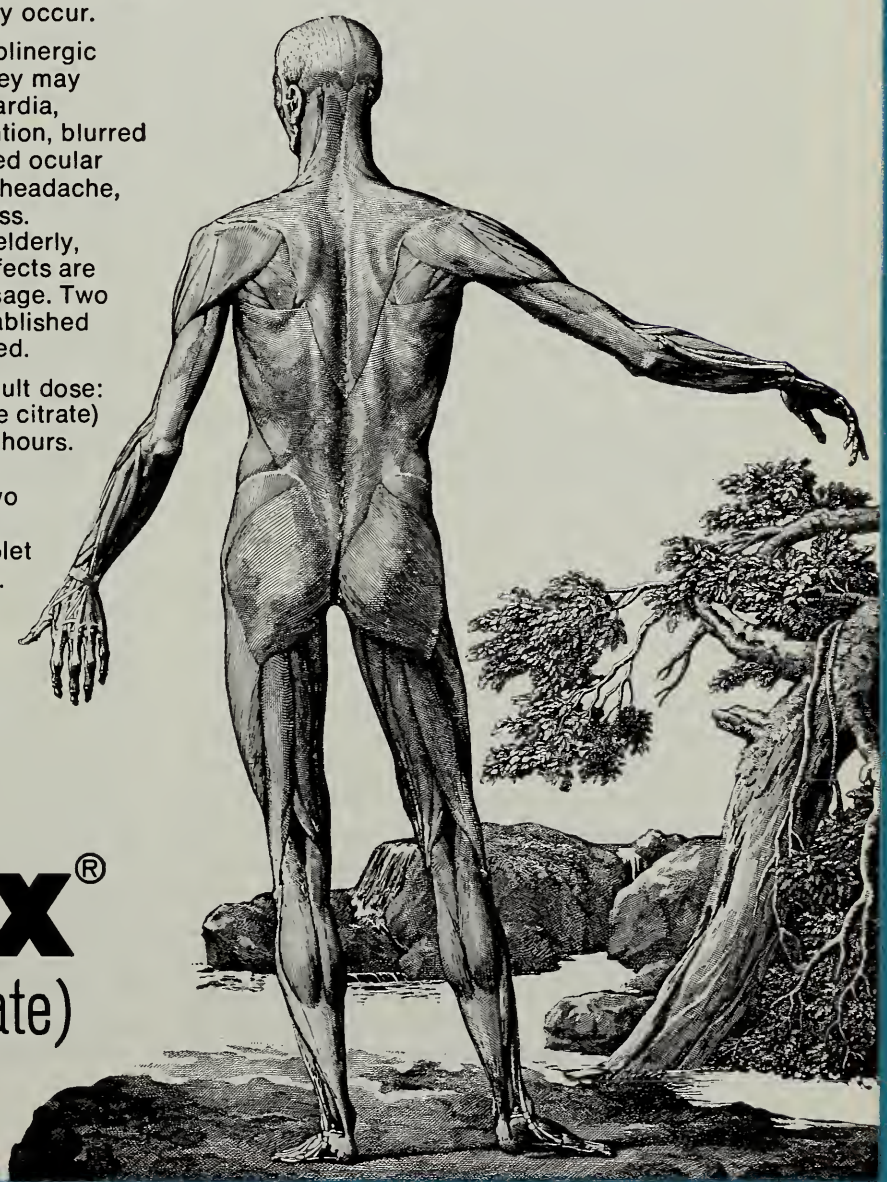
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In legend and fact, our feathered friends have turned in a good account of themselves in military and political activities. Noah dispatched a dove which returned with an olive branch. Carrier pigeons are as old as history and have generally been used for military purposes. Ornithologists have long been investigating the uncanny ability of birds to outperform the best aerial and surface navigational systems as they fly with perfect accuracy from one hemisphere to another.

Of late, we have the hawks and doves as symbols firmly associated with policies of fight or quit in Vietnam. This has got to be a ceaseless source of ribbing for the serious researchers at Ole Miss.

On the serious side, the project is sensible and worthy, if for nothing more than unlocking some of nature's amazing secrets of natural, instinctive endowments in simple species which more often than not surpass man's best effort.

On the lighter side, expect Mississippi State University alumni to have a few choice remarks about the project and the institution doing the research. Of course, MSU may have to start working on an anti-bird defense system, just in case.—R.B.K.

AMA-ERF: Need, Opportunity—No Argument

The cost of medical education is high and going higher. Nobody argues to the contrary.

The worthy and apt applicant for admission to a medical school who needs help must receive it. Nobody argues to the contrary.

Our medical schools, hard-pressed to perform bigger, more costly tasks, to increase enrollments and the number of graduates, and to dig deeper into needed areas of medical research, must have help financially. Nobody argues to the contrary.

But the best argument *for* these propositions is the physicians' own American Medical Education and Research Foundation. Born of need, nurtured to maturity in promise, and proven effective with growth, AMA-ERF is unique in support of professional education and research.

It all began in 1951 with the old American Medical Education Foundation which had as its purpose the gathering of voluntarily given funds for distribution to financially ailing medical schools under a simple formula related to enrollment. In 1957, the American Medical Research Foundation was organized, also by physicians through their AMA, and it had as its goal the improvement of health through scientific and medical research. Unification of the two foundations as AMA-ERF was approved by the AMA House of Delegates as the logical means of making both programs more effective.

Dues paid by American physicians to AMA support the operational expense of the foundation, so that for every dollar given, 100 cents goes into the program. And, incidentally, the operational expense is all but negligible, because state medical associations, component medical societies, and the Woman's Auxiliary carry a lion's share of publicizing the program and in soliciting gifts.

AMA-ERF emphasizes a three-prong thrust: Distributing unrestricted funds to medical schools; maintaining a loan program for students, interns, and residents; and supporting AMA's biomedical research institute.

In 1968, the state medical association, in partnership with AMA-ERF, was able to present the University Medical Center with an unrestricted gift of $11,473 of which 80 per cent was given by Mississippi physicians and members of the Woman's Auxiliary. The remaining 20 per cent represented the common distribution to the university on a student prorata basis.

The loan program is guaranteed by the foundation's securing loans on a 12.5-to-1 ratio. Thus, for every dollar AMA-ERF is able to put up as security, a loan of $12.50 may be made by participating regional bank to a student, intern, or resident. Millions of dollars have been made available to trainees under loan terms geared to practice-related repayment, and those at UMC have been major beneficiaries of these loans.

The biomedical institute boasts an elite assembly of distinguished scientists who work as their respective fields of interests dictate in the biomedical and life science areas. They are under no pressure—as is true under most grant programs—to produce papers or results, and creative investigation accordingly flourishes without concomitant concern over project finances.

The first appeal for voluntary support of AMA-ERF has been sent to Mississippi physicians by the dean and director of UMC, Dr. Robert E. Carter. The timetable for friendly reminder of meritorious opportunity calls for a letter within a fortnight from the president of the association, Dr. Joseph B. Rogers. There will be additional reminders of this opportunity.

Addressing a major meeting at Chicago re-

cently, Dr. Dwight L. Wilbur of San Francisco, president of AMA, urged that each American physician give $100 annually to AMA-ERF. From the membership of AMA alone, Dr. Wilbur stressed, this level of giving would generate $20 million annually. He didn't say so, but this sum would be worth three times as much federal money, because AMA-ERF distributions are unrestricted, meaning that the medical school is free to use the money where it is most urgently needed without regard to the severe limitations accompanying public funds.

Nobody argues the need, and everyone can agree on the opportunity. That's why every physician will find satisfaction in making his gift today.—R.B.K.

Medical Planks in the Party Platforms

Medical issues in the current presidential campaign have been almost totally obscured by the war in Vietnam and crime in the streets. But in the something-for-everybody platforms, both the Democrats and Republicans had plenty to say about health, medical care, and private medicine. The third major contender, Governor George Wallace, doesn't have a platform in the major political party sense, but he, too, has something to say about the circumstances under which medical care should be rendered.

In the Democratic and Republican platforms, both parties cited the importance of the role of private medicine in the development of government health care programs. Only the Republicans said it better and put a good deal more emphasis on private enterprise than did the Democrats.

"While believing no American should be denied adequate medical treatment," the GOP plank states, "we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner."

The plank continues to pledge "to encourage the broadening of private health insurance plans, including extensions to cover mental illness."

The Democratic plank begins by saying that "Through a partnership of government and private enterprise, we must develop new coordinated approaches to stem the rise in medical costs without lowering the quality or availability of Medicare care." From this dollar-related beginning, the plank echoes faithfully the health programs of the administrations during the past eight years.

Without being specific, the Democrats indicate support for universal government health insurance, or, to say the least, wide and substantial expansion of Medicare and Title XIX, or both.

Claiming to have made "giant steps" over the past eight years "in assuring life and health for (the nation's) citizens," the plank says: "We Democrats are determined to take those final steps necessary to make certain that every American, regardless of economic status, shall live out his years without fear of the high costs of sickness."

The Democratic panacea for depressing health care costs includes more outpatient care, group practice (closed panel plans), increased neighborhood health centers (as now conducted under the OEO poverty programs), and greater use of subprofessionals in the health care field.

While the Democrats spoke almost incessantly of health care costs, the Republicans mention it only once, stating that "inflation produced by the Johnson-Humphrey administration" was a major factor in the increases in health care costs.

Prior to each national convention, AMA spokesmen appeared before the platform committee of each party. And while each spokesman was, naturally, a member of the party before whose convention committee he appeared, the statements presented were identical.

In all fairness to Governor Wallace, he has frequently mentioned "returning control of the hospitals to the states," and he has underscored the need for local control of publicly-supported programs of health care.

Almost no American will cast his vote for President of the United States with his candidate's position on health care as the deciding factor, but for the well-being of the patient, the structure and capacity of the private care delivery system, and the professional futures of many Americans, these positions are critically important.—R.B.K.

Blood and Stamps

When recently asked to name the most pressing problem in the field of blood banking, the chairman of the state medical association's committee, Dr. Kenneth M. Heard of Jackson, unhesitantly replied that it was the securing of donors. Nor is this a local problem, concerning only those in Mississippi who provide blood banking and transfusion services, because the American Association of Blood Banks has made a proposal to dramatize this need to the nation.

AABB President John A. Shively has asked the Postmaster General of the United States to issue a commemorative postage stamp to encour-

age voluntary blood donation. Dr. Shively told Postmaster General Marvin Watson that "blood donation is not keeping pace with the increased use of blood." He said that the serious need for more voluntary donors has come about because of rapid developments in the chemotherapy of leukemia and other forms of cancer and because of advances in cardiovascular surgery.

Dr. Shively called attention to successes realized by issuing commemorative postage stamps in publicizing other national needs. The proposal has been proved useful, because the state medical association's collection of postage stamps relating to medicine has copies of blood donor issues from France, Japan, Monaco, and Russia. Generally speaking, according to philatelists, the United States has not made full use of the communications potential inherent in commemorative postage stamps. Since we must have blood and stamps, the idea wouldn't cost the taxpayers a red cent. It might save a life.—R.B.K.

LETTERS

SIRS: As most obstetricians, general practitioners and pediatricians are aware, there has recently become available, for clinical use, a new product, namely, $Rh_o(D)$ Immune Globulin (Human), under the trade name, "RhoGAM" (Ortho). When injected into an Rh negative woman within 72 hours after delivery or abortion of an Rh positive infant, RhoGAM will prevent maternal Rh sensitization in apparently all cases, according to extensive clinical trials,[1, 2, 3, 4] probably by neutralizing the antigen[5] of any Rh positive fetal cells which have transplacentally entered the maternal circulation at the time of placental detachment.[6]

It is evident that the proper use of this new product depends on discovering, before 72 hours postpartum, which women are Rh negative. In other words, adequate case-finding, within the specified time limit, is essential to the effective use of this product. Because of this, it was decided at the Mississippi Baptist Hospital that all women admitted for obstetrical purposes should have an Rh type and ABO grouping routinely done on admission.

Although many patients have had an Rh type done by their physician before delivery, a routine test on admission was considered desirable, to make sure no Rh negative patients are missed, and also to detect possible errors in previous Rh typing. Such an error could mislead the physician into recommending RhoGAM when it is not needed, or dangerous, as in a D^u mother mistyped as $Rh_o(D)$ negative; or into failing to give RhoGAM when it is needed, possibly making the physician liable, if Rh sensitization should develop in a subsequent pregnancy. Likewise, the hospital might be judged negligent, if it failed to test a mother for Rh type during her admission, and she later became sensitized.

Therefore, the following routine was set up with the joint approval of the obstetrics, general practice, and pathology staffs:

(1) The Blood Bank will do a routine Rh typing and ABO grouping on all women admitted for delivery or cesarean section.

(2) If the mother is $Rh_o(D)$ or D^u positive, the result is reported, and nothing further is required.

(3) If the mother is $Rh_o(D)$ and D^u negative, the obstetrician is notified. All further testing is done only on the obstetrician's request.

(4) Upon the obstetrician's request, the mother's serum is tested for Rh antibodies to see if she has already been sensitized (Hemantigen test). If antibodies are present, she is not a candi-



"Which is more important, his breathing or the Ming dynasty?"

date for RhoGAM. If antibodies are absent, the infant's blood is checked.

(5) The infant's cord blood (routinely obtained at delivery and held in the blood bank) is typed for $Rh_o(D)$ and D^u (plus ABO). If it is $Rh_o(D)$ and D^u negative, nothing further need be done, as the mother does not need RhoGAM.

(6) If the infant is $Rh_o(D)$ or D^u positive, a direct Coombs' test is done. If it is positive, Rh sensitization of the mother has probably already occurred, and she probably is not a candidate for RhoGAM. However, weakly positive Coombs' tests may be seen in hemolytic disease of the newborn due to ABO incompatibility.

(7) If the infant is $Rh_o(D)$ or D^u positive and Coombs' negative, RhoGAM therapy is indicated for the mother, unless she will definitely have no more pregnancies. (Even if she expects no more pregnancies, it would still be a good idea to give RhoGAM, both to protect the fetus, should an unexpected pregnancy occur, and to protect the mother against Rh sensitization and possible hemolytic reaction, in the event she should ever get a mismatched blood transfusion.)

It was thought by the staff that RhoGAM should be given in cases of second trimester abortions and third trimester prematures, both stillborn and live deliveries, as well as in term deliveries and cesarean sections. We have been unable to ascertain the exact likelihood of sensitization of an Rh negative mother who aborts an Rh positive fetus early in pregnancy, or who has an ectopic pregnancy. It is known that the Rh antigens of the fetus are well-developed by six weeks' gestation, and that only 0.25 ml. of fetal blood escaping across the placenta into the maternal circulation may cause sensitization of the mother.[7] Probably, the danger of maternal sensitization increases with fetal age. Thus, when an Rh negative woman has an abortion, in which the fetus is too small or macerated to yield an adequate blood sample for typing, the decision to administer RhoGAM will depend on the following considerations:

(1) The mother must not already be demonstrably sensitized; i.e., no anti-Rh antibodies in her serum (negative Hemantigen test).

(2) The father must be $Rh_o(D)$ or D^u positive.

(3) If the abortion occurs in the second trimester, the mother should probably receive RhoGAM. Abortions in the first trimester (or ectopic pregnancies) present a less definite indication for RhoGAM, although it probably would be safest to give it, especially if further pregnancies are contemplated. However, it was felt that the physician would be justified in withholding RhoGAM

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Vitamin B_2	7.5 mg
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Vitamin B_{12}	50 mcgm
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anticostive, *adj.* (*anti* **opposed to** + *costive* **causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?**

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until this question is resolved by further clinical studies, as it probably will be in the near future.

(4) Compatibility in the ABO group between father and mother presents a stronger indication for RhoGAM than incompatibility.[7]

(5) Primiparity presents a stronger indication for RhoGAM than multiparity.[7]

(6) A short interval (less than one year) since a previous pregnancy is a stronger indication for RhoGAM than a long interval.[8]

It should be noted that RhoGAM has no protective effect whatever in hemolytic disease of the newborn due to ABO or Kell incompatibility, and, in fact, it is contraindicated in such cases.

WILLIAM B. WILSON, M.D.
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JACKSON, MISS. 39201

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POSTGRADUATE CALENDAR

October 3-4, 1968

ARTHRITIS SEMINAR

This postgraduate education program will cover aspects of practical rheumatology. Guest lecturers will be Dr. Charles A. Rockwood, Jr., associate professor and head of the division of orthopedic surgery at the University of Texas Medical School at San Antonio; Dr. Charley J. Smyth, professor of internal medicine and head of the rheumatic disease section at the University of Colorado in Denver; and Dr. Thomas E. Weiss, head of the section on rheumatology, Department of Internal Medicine at Ochsner Clinic, New Orleans.

FUTURE CALENDAR

October 15-17, 1968
MISSISSIPPI ACADEMY OF GENERAL PRACTICE

October 24, 31, and November 7, 1968
CIRCUIT COURSE, GREENWOOD

October 25, November 1 and 8, 1968
CIRCUIT COURSE, TUPELO

November 7-8, 1968
DR. WESTON M. KELSEY, BOWMAN-GRAY SCHOOL OF MEDICINE
VISITING PROFESSOR IN PEDIATRICS

November 8, 1968
CARDIOPULMONARY RESUSCITATION TRAINING COURSE

January 8, 15, 22, 1969
CIRCUIT COURSE, BILOXI

January 9, 16, 23, 1969
CIRCUIT COURSE, HATTIESBURG

January 24, 1969
DERMATOLOGY SEMINAR

January 28, 1969
CIRCUIT COURSE, COLUMBUS

February 19, 1969
SYMPOSIUM ON HUMAN SEXUALITY

February 25, 1969
CIRCUIT COURSE, COLUMBUS

March 4, 1969
CIRCUIT COURSE, MERIDIAN

March 7, 1969
KIDNEY SEMINAR

March 26-28, 1969
CARDIOVASCULAR SEMINAR

April 1, 1969
CIRCUIT COURSE, MERIDIAN

April 15, 1969
CIRCUIT COURSE, NATCHEZ

April 22, 1969
CIRCUIT COURSE, COLUMBUS

May 6, 1969
CIRCUIT COURSE, MERIDIAN

May 12-15, 1969
MISSISSIPPI STATE MEDICAL ASSOCIATION

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Glyceryl guaiacolate 100 mg.
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Non-narcotic for 6-8 hour cough control
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Clears sinuses and nasal stuffiness as it relieves cough
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Phenylephrine hydrochloride . . . 10.0 mg.
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EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

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PERSONALS

HERSCHEL J. BLAKENEY of Amory has been appointed a member of the Mississippi Commission on Hospital Care by Governor John Bell Williams. The seven-member body supervises the licensure of hospitals and oversees the Hill-Burton program in the state.

ELDON L. BOLTON placed first in the Biloxi Yacht Club's annual Lipton Cup elimination series. He placed as top expert skipper with a winning 914 per cent. A past president of the Mississippi Academy of General Practice, Dr. Bolton has chaired a number of key committees of the state medical association and is a member of the House of Delegates.

JAMES M. BROCK has been named a member of the McComb Housing Authority by the city council, entering service in a post held for years by his late father, L. W. BROCK.

JAMES V. BRUCE has become associated in practice with S. S. KETY at the Kety Clinic, 1000-5th Ave., Picayune. Dr. Bruce is a graduate of the University of Yucatan (Mexico), and he received his internship at Tucson, Ariz.

JACK B. CAMPBELL of Jackson appeared as featured speaker at the recent monthly meeting of the Central Mississippi Chapter of the American Association of Medical Assistants.

JOHN D. COFFEY, JR., of Natchez served as leader to a group of 20 Boy Scouts during a trip to Canada last month. Highlight of the trek was a canoe trip. Thirteen of the boys were from Natchez, and seven others represented McComb, Canton, and Jackson.

DONALD E. COOK has announced the opening of his offices at 1508-24th Ave. in Meridian where he will limit his practice to orthopaedic surgery. He recently completed his residency training at the University Medical Center.

JAMES R. DAY has become associated with the Children's Medical Group, 800 Carlisle St., Jackson, where the seven member clinic limits its practice to pediatrics.

ARMIN F. HAERER of Jackson is serving a two months voluntary tour as a teaching member of the professional staff aboard the S. S. HOPE. The ship, principal activity of the People-to-People Health Foundation, is calling at Ceylon, the tiny island nation at the southern tip of India, for a 10 months teaching mission. Dr. Haerer is assistant professor of neurology at the University Medical Center. He is a graduate of the University of Michigan School of Medicine.

J. E. HILL has joined the Wilson Clinic at Hollandale where he will be associated with CLARENCE G. HULL and JAMES H. SAMS in the general practice of medicine. Dr. Hill is a graduate of the University of Mississippi, and he received his medical degree at the University Medical Center.

M. E. HINMAN of Vicksburg has joined the staff of the Street Clinic where he will be chief of the department of urology. A medical certificate graduate of the old two year University of Mississippi School of Medicine at Oxford, Dr. Hinman received his medical degree at the Louisiana State University School of Medicine and interned at the New Orleans Charity Hospital. After five years in general practice, he completed a residency in urology at the University Medical Center and located at Vicksburg. He is a diplomate of the American Board of Urology and currently serves as secretary of the West Mississippi Medical Society.

FRANCIS E. MCCULLOUGH of Jackson has announced the association of WILLIAM R. ARMSTRONG in practice limited to ophthalmology. Dr. McCullough's offices are located at 955 N. State St.

JOHN W. MCFADDEN has announced the opening of his offices at 218 W. Broad St. in West Point. He will limit his practice to pediatrics.

MARY ALICE LEE of Jackson has been appointed director of Mental Health Services of the Mississippi State Board of Health, succeeding ESTELLE A. MAGIERA who recently retired after 25 years service during which she organized and developed the program. Dr. Lee is a graduate of the University of Alabama, and she received her M.D. degree from the University of Tennessee College of Medicine. After serving four years as clinician in the Hinds County Health Department, she entered psychiatric training, completing her residency at the University Medical Center. Prior to her recent appointment, Dr. Lee has been regional director of the mental health clinic at Jackson.

JAMES O. MANNING of Jackson has been elected vice president of the Hinds County University of Mississippi Alumni at their recent annual meet-

ing. Dr. Manning limits his practice to orthopaedic surgery and is associated with GEORGE D. PURVIS, THOMAS C. TURNER, and WILLIAM B. THOMPSON at 421 S. Stadium Circle.

J. DANIEL MITCHELL of Jackson has been elected chief-of-staff at Hinds General Hospital for 1968-69. One of Dr. Mitchell's first duties will be to attend the National Hospital Medical Staff Conference to be conducted at Estes Park, Colorado in October.

CHARLES M. MURRY of Oxford has been elected a member of the Board of Trustees of Millsaps College. A 1941 graduate of Millsaps, Dr. Murry earned his medical degree at Jefferson Medical College. He limits his practice to otolaryngology and holds a faculty appointment at the University Medical Center.

ROBERT SCHMIDT has joined his father, HARRY J. SCHMIDT, at Biloxi where he will limit his practice to obstetrics and gynecology. Dr. Schmidt is a graduate of the Tulane University School of Medicine, and he received his specialty training at the New Orleans Charity Hospital. He has just completed naval service, being discharged as a lieutenant commander.

ROBERT B. THOMPSON of Jackson appeared as an essayist before the New York Academy of Sciences' Second International Conference on Problems of Cooley's Anemia at New York City. Dr. Thompson is associate professor of clinical laboratory sciences at the University Medical Center.

NEW MEMBERS

The following physician has been elected to membership by his component medical society in the Mississippi State Medical Association and the American Medical Association.

LEACH, JOHN EDWARD, Moss Point. Born Burlington, Wis., Sept. 20, 1908; M.D., University of Wisconsin Medical School, Madison, 1936; interned Research Hospital and Medical Center, Kansas City, Mo., one year; internal medicine residency, Augustana Hospital, Chicago, Ill., two and one-half years, Mayo Graduate School of Medicine, Rochester, Minn., one month, Walter Reed General Hospital, Washington, D. C., one month; elected May 1, 1968, by Coast Counties Medical Society.

DEATHS

GRIFFITH, ERNEST L., Columbia. M.D., Tennessee Medical School; practiced medicine in Jefferson Davis and Covington counties, retiring from active practice about 50 years ago when he was stricken with arthritis; died June 25, 1968, aged 91.

HARVEY, ALTUS BUREN, Tylertown. M.D., Tulane University School of Medicine, New Orleans, Louisiana, 1921; interned Santo Tomas, Panama, one year; post graduate training Tulane University School of Medicine, 1934, by grant of the Commonwealth Foundation; post graduate training in Neoplastic diseases, Tulane University School of Medicine, 1947; died Aug. 26, 1968, aged 75.

HUGHES, THACK G., Clarksdale. M.D., University of Kentucky College of Medicine, Lexington, 1905; residency New York Polyclinic Medical Center and Hospital, 1916-1926; member Fifty Year Club; Emeritus member Mississippi State Medical Association and American Medical Association; died Aug. 23, 1968, aged 88.

LOVE, CHARLES H., Aberdeen. M.D., University of Tennessee College of Medicine, Memphis, 1915; interned Memphis General Hospital, Memphis, Tennessee, 1915; three months post graduate training Vanderbilt University School of Public Health, 1937; died Aug. 14, 1968, aged 78.

RUOFF, JOHN S., JR., Natchez. M.D., Tulane University School of Medicine, New Orleans, Louisiana, 1911; interned U. S. Marine Hospital, New Orleans, Louisiana, 1912-1913; Emeritus member Mississippi State Medical Association and American Medical Association; died Sept. 1, 1968, aged 79.

SCALES, HUNTER L., Starkville. M.D., Vanderbilt University School of Medicine, Nashville, Tennessee, 1907; interned Butterworth Hospital, Grand Rapids, Michigan, 1907; Emeritus member Mississippi State Medical Association and American Medical Association; died Aug. 4, 1968, aged 83.

Meridian Team Gets Top Examination

Any football fan in Mississippi knows that the Meridian Wildcats are the top gridiron squad in the state, but members of the East Mississippi Medical Society have made certain that they are also among the healthiest.

An unprecedented medical and dental examination program, developed by Meridian physicians, subjected the Wildcats to thorough physical scrutiny with the beginning of the current season. Speaking for his colleagues, Dr. H. Lowry Rush, Jr., of Meridian, said that "our athletes deserve the best that is available in this community and our high school pre-football examination takes a back seat to none that we are aware of.

"Our high school and junior high coaches have a dedication to the Christian, mental, and physical development of our young athletes in Meridian, and our medical and paramedical people are proud to be a part of the Wildcat family."

The examination includes screening at eight stations. First, weight and height are recorded. The second stage is a hemoglobin and urianalysis by registered laboratory technicians.

At the third station, a blood pressure recording is made of each candidate for the team, and station four is briefly uncomfortable, as a graduate nurse administers a tetanus booster.

Members of the dental profession at Meridian man station five where mouth pieces or teeth guards are individually fitted by a dentist. Station six is a phonocardioscan unit examination to detect murmurs and other defects. Meridian physicians believe that this portion of the examination is a first in high school football.

Players are individually examined by a physician at station seven, where a general physical is given. The final stage, number eight, is a chest x-ray.

Championship-winning Meridian Head Coach Charles Garrett said that "I think it's one of the finest things to happen to a football program in the history of Mississippi sports."

Services of the physicians, dentists, nurses, medical technicians, and others on the health care team are enthusiastically donated to the program. Dr. Rush emphasized that the rigorous examination is one part of the overall sports injury prevention program.

He said that he has been corresponding with physicians over the state with a view toward organizing a Mississippi Association of Sports Physicians. He is scheduled to meet with the state medical association's Council on Medical Service during the fall to discuss the feasibility of establishing an *ad hoc* Committee on Medical Aspects of Sports.

Dr. William J. Gillespie of Jackson, chief of the State Board of Health's Heart Disease Control Unit, told the JOURNAL that "I personally think that this is a most complete examination and would like to see all the athletes in the state receive a comparable work up."

Clarksdale Physician Gets Life Sentence

A Coahoma County circuit court has sentenced Dr. Luther W. McCaskill of Clarksdale to life imprisonment following his conviction on a charge of murder by abortion. Attorneys for the physician stated that they will move for a new trial or appeal the decision to the Mississippi Supreme Court.

The charge against Dr. McCaskill was in connection with the death of Mrs. Emma Flowers Hurt of Greenwood, a 22-year-old mother of two children. It was brought last spring, after which the defendant was freed on a $15,000 bond. He was returned to custody after indictment by the grand jury on four charges in July.

The capital case was tried under a law sponsored in the 1952 Regular Session of the legislature by the Mississippi State Medical Association. The enactment makes any participation in criminal abortion a felony, punishable by prison sentence up to 10 years. Where the woman dies, the law provides for a charge of murder.

Evidence presented during the trial showed that the defendant had issued a death certificate for Mrs. Hurt giving coronary occlusion as the cause of death. A pathologist's report stated that the cause was due to hemorrhage of the uterus.

The case was prosecuted by District Attorney Hoke Stone who was assisted by Coahoma County Attorney George Fleming. Harvey T. Ross of Clarksdale represented Dr. McCaskill as defense counsel.

Accounts of the trial said that the jury deliberated less than an hour in reaching its decision of guilty. Under the law, the panel had the option of imposing the death penalty or life imprisonment. The trial lasted three days, but about half of the time was needed for selection of the jury.

Council on Scientific Assembly Schedules 101st Annual Session for Biloxi in '69

Final plans for the format and scheduling of the 101st Annual Session of the association were adopted by the Council on Scientific Assembly during a recent meeting at Biloxi in the Buena Vista, headquarters hotel for the meet.

Dr. Walter H. Simmons of Jackson, chairman of the council, said that dates of the annual session are May 12-15, 1969, with the House of Delegates convening on Monday and the Scientific Assembly beginning on Tuesday.

General sessions are set for two and a half days beginning with obstetrics and gynecology on Tuesday, May 13, with surgery set for the afternoon. The Wednesday sessions slate medicine for the morning and an afternoon program of general practice and preventive medicine.

The half-day general sessions Thursday morning feature concurrent programs for pediatrics and eye, ear, nose, and throat. The concluding meeting of the House of Delegates will occupy the afternoon of May 15.

Dr. Simmons and his colleagues on the council said that the technical and scientific exhibits will open on the morning of May 13 at the Buena Vista.

"We will stress the support given our annual session by the technical exhibitors," Dr. Simmons said in behalf of the council, "and we feel it urgent that each member attending the meeting make a personal expression of appreciation to each exhibitor.

"The council earnestly desires for each technical exhibitor to realize the full potential in his professional communications investment in the Mississippi annual session," Dr. Simmons added. "The exhibits not only afford physicians an opportunity to renew friendships and acquaintances with professional service representatives, but they are also educational and pertinent to the changing drug and equipment picture in this era of forward thrust in medical science."

Expressing satisfaction over the growing scientific exhibit which has increased three-fold in two years, the council said that it anticipates an outstanding group of exhibits by physicians, major medical institutions, voluntary health organizations, and health-related agencies of government.

To encourage both the number of presentations and quality of individual scientific exhibit offerings, the council is proposing to increase the cash honorarium for the exhibit by a member of the association adjudged best to $500 from the present $200.

Also programmed for prominent spots on the four day schedule are meetings of about 15 specialty societies. Many will coincide as to date with related general sessions of the Scientific Assembly, the council said.

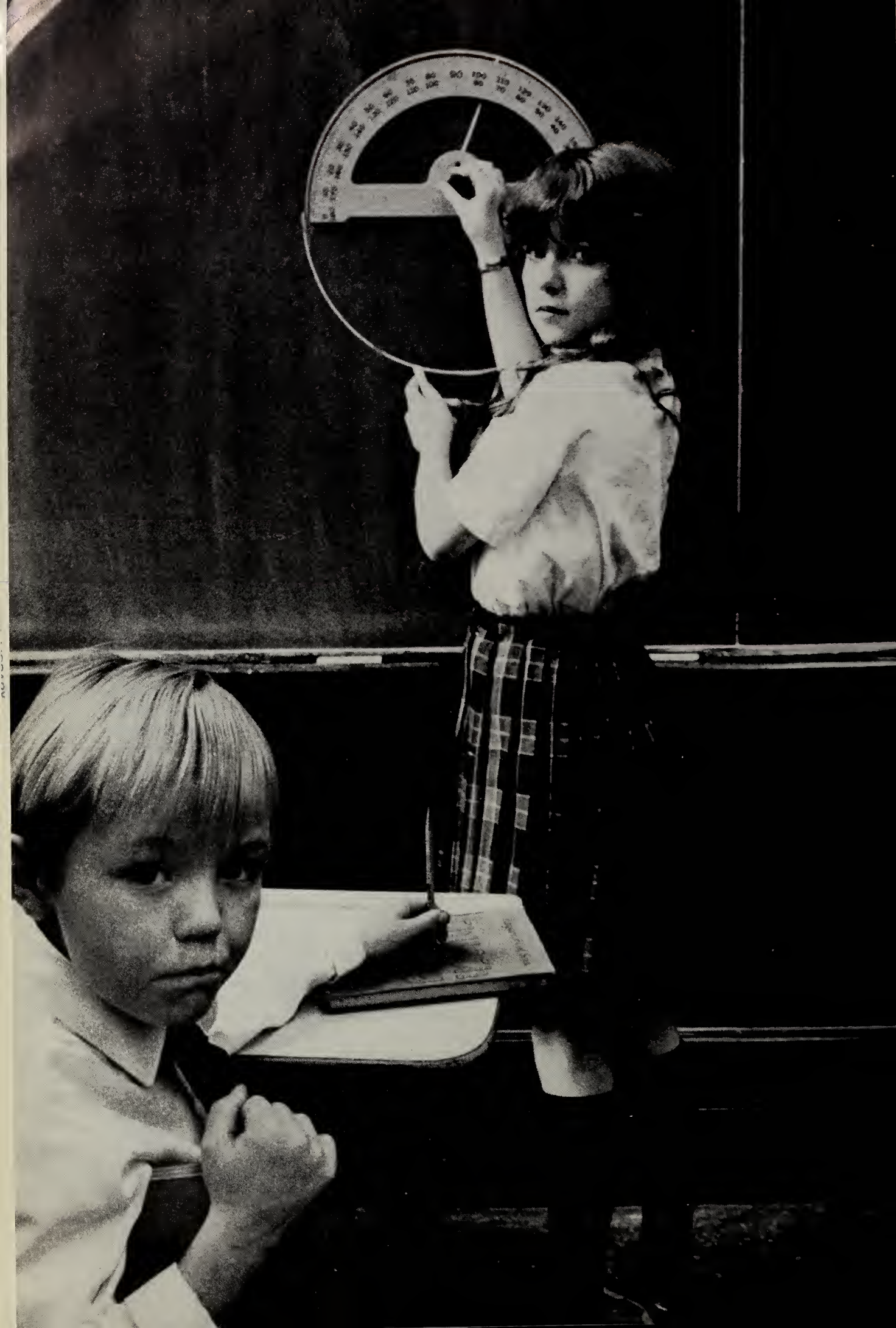
Association-sponsored functions will include the traditional luncheon honoring members of the Fifty Year Club, and a major social occasion is planned for Wednesday evening, May 14. Medical alumni groups, including Ole Miss, Tennessee, Tulane, and Vanderbilt, will enjoy evening social occasions.

The council also made plans for the concurrent annual session of the Woman's Auxiliary, May 12-14. It is understood that the general chairman and other Auxiliary meeting officials will be announced at a later date.

The year 1969 marks the first of continuous Gulf Coast meetings as decided by the House of Delegates in 1967. Convention facilities at Jackson were deemed inadequate for the annual session. Only the Buena Vista at Biloxi can accommodate the growing space requirements for the association's session, the council noted.

Officials of the Coast hotel said that the modernization and refurbishing program is continuing. Plans call for work on the original or west section of the Buena Vista Beach Motel during 1968 and early 1969. Almost half of the hotel rooms have been remodeled and redecorated, and this program will also extend into 1969, according to the Buena Vista management.

Other meeting attractions will include the an-



pinworms in this school?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections which are estimated to occur in from ⅓ to more than ½ of all American children from every social level

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nual association golf tournament, and the council has authorized organization of a tennis tourney at the 1969 meet.

In addition to the general session and specialty society offerings in the Scientific Assembly, breakfast roundtable discussions and medical motion pictures are planned. On mornings with breakfast roundtables, there will be no conflicting film offerings. Dr. Calvin Hull of Jackson will serve again as medical motion picture chairman.

The 15-member Council on Scientific Assembly is made up of the secretary-treasurer, Dr. Simmons, who is constitutionally designated as chairman, and the chairmen and secretaries of the seven scientific sections.

Representing the Section on EENT are Drs. John C. Suares of Greenville, chairman, and James K. Williams, Jr., of Pascagoula, secretary. Drs. Hardy B. Woodbridge, Jr., and W. Johnson Witt, both of Jackson, are respectively chairman and secretary of the Section on General Practice.

Officials of the Section on Medicine are Drs. John R. Shell of Vicksburg, chairman, and C. Ralph Daniel, Jr., of Jackson, secretary.

Heading the Section on Obstetrics and Gynecology are Drs. O. B. Wooley, Jr., of Jackson, chairman, and J. Purves McLaurin, Jr., of Oxford, secretary. Drs. Wallace S. Sekul of Biloxi is chairman of the Section on Pediatrics, and the secretary is Dr. William F. Sistrunk of Jackson.

Dr. Steven L. Moore of Jackson is chairman of the Section on Preventive Medicine, and the section secretary is Dr. Frank J. Morgan, Jr., also of Jackson.

Officers of the Section on Surgery are Drs. Dawson B. Conerly, Jr., of Hattiesburg, chairman, and M. Beckett Howorth of Oxford, secretary.

Section officers are elected by their colleagues in their respective sections with chairmen serving one year only and secretaries, for three year terms. All are automatically members of the House of Delegates while in office.

Bank Cards Are Ethical For Medical Fees

Members of the Mississippi State Medical Association may ethically participate in bank credit card programs, according to a policy ruling by the Board of Trustees at its recent regular meeting. The Board acted to approve a special study and report by the chairman, Dr. C. D. Taylor, Jr., of Pass Christian.

Dr. Taylor reported to the Board that development of bank credit card programs was rapidly increasing in the state and that a heavy number of inquiries had been received from physicians as to the propriety of accepting the cards in lieu of cash or check from patients for services rendered.

The ruling states that "it is not unethical for a physician to accept a bank credit card in payment for professional services rendered," but Dr. Taylor added that the ruling carries certain qualifications.

Under no circumstances may a physician's name be ethically listed in a bank credit card directory nor are use of the cards in payment of larger fees to be encouraged, since this usually results in greater expense to the patient.

Dr. Taylor said that the Board of Trustees' decision was in the area of policy, because it was essentially an action adopting the position of the Judicial Council of the American Medical Association. The ruling does not make ethical use of "third party" credit cards such as American Express for payment of medical fees.

The AMA Judicial Council's ruling is based on the long-accepted ethical tenet that "the medical profession cannot dictate to patients how they shall finance their medical bills." The ruling also recognizes that bank credit cards, costing nothing as to acquisition by the user, are not only a convenience and substitute for cash, but they are also a financing mechanism.

Two major bank credit systems are being developed in the state, BankAmericard and Master Charge. Each is an ethical medium of exchange for payment of professional services.

Dr. Taylor said that the Board of Trustees specified three major requirements to be met in use of bank cards for payment of physicians:

—The financial and professional integrity of the bank card plan should be demonstrated, and the local medical society should negotiate with the plan to make sure that charges to physicians by the bank (the discount) are reasonable. The plan should be open to all physicians on the same terms, and no physician's name may ethically be listed in a bank card directory of participating vendors.

—Because of his participation, if he elects to do so, no physician may ethically increase his fees for medical services. He may not use the card to solicit patients, nor may he encourage patients to use such cards. His position is that he accepts the plan as a convenience to patients who elect to use it. Plaques, signs, or other devices announcing a physician's participation shall be kept to a discreet and dignified minimum and

must not be visible outside of his offices.

—Use of bank credit cards for payment of larger fees (which might normally be paid to the physician in installments without interest) is not to be encouraged.

The Board's ruling will be made available to secretaries of component medical societies and is already in the possession of each Trustee, Dr. Taylor said.

UMC Augments Faculty Total to 123

The University of Mississippi School of Medicine has added 17 new faculty, bringing the number of full-time members to 129, and has announced 19 faculty promotions.

New appointments in the School of Medicine include an associate professor, six assistant professors and nine instructors. The announcement was made earlier of the appointment of Maj. Gen. Robert E. Blount, USA(MC) Ret., as an assistant dean of the School of Medicine and associate professor of preventive medicine. Dr. Blount will also be a professor of medicine (clinical) at the Medical Center.

Added at the associate professor level is Edwin Bridgforth, preventive medicine (biostatistics), who comes to the University Medical Center from the University of Texas Medical Branch at Galveston.

Assistant professors joining the faculty are: Dr. Bernard Patrick, neurosurgery; Dr. Edmond Venator, neurosurgery (research); Dr. C. Kaya Aydar, obstetics-gynecology; Dr. Carl Jones, physiology and biophysics; Dr. Konrad Scheel, medicine (research), and Dr. Otmar Wassermann, pharmacology.

The Department of Surgery added three instructors: Ralph Frybarger (Communication Disorders) and Miss Carla Sorrells and Mrs. Linda Farmer Mills, both in otolaryngology.

Six other departments added one instructor each: Dr. John Neal Brown, biochemistry; Dr. Robert Baringer, psychiatry; Dr. William Bright, radiology; Dr. Aida Malonzo, obstetrics-gynecology; Dr. John Rawson, pediatrics; and Dr. Marvin Jeter, medicine. Dr. Jeter is also director of outpatient services for University Hospital.

Faculty members elevated to full professorships are Dr. Robert D. Currier, medicine, and codirector of the Mississippi Regional Medical Program Stroke Unit; Dr. Glenn Gentry, microbiology; Dr. M. Don Turner, surgery (research)

Hill Crest
HOSPITAL
(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205-836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 43 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . .
. . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . .
ALABAMA HOSPITAL ASSOCIATION . . .
BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals and is also approved for Medicare patients.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

and associate professor of physiology and biophysics, and Dr. Patrick H. Lehan, medicine. Dr. Lehan is also the newly designated Mississippi Heart Association William D. Love Research Professor of Cardiology.

Nine School of Medicine faculty were promoted to the rank of associate professor: Dr. Richard Boronow, obstetrics-gynecology; Dr. Ben Douglas, medicine (research) and assistant professor of physiology and biophysics; Dr. Carl Evers, pathology; Dr. James Grogan, surgery (research) and assistant professor of microbiology; Dr. Armin Haerer, medicine (neurology), and Dr. Connie McCaa, biochemistry. Also, Dr. Jose Montalvo, pediatrics; Dr. Paul Morse, microbiology (oncology), and Dr. Robert Thompson, clinical laboratory sciences.

Dr. James Suess, associate professor of psychiatry, has been named acting chairman of the Department of Psychiatry.

Promoted to assistant professor were Dr. Jeanne Bonar, medicine; Dr. Kermit Gaar, physiology and biophysics; Dr. William Hicks, pediatrics; Dr. Robert Smith, neurosurgery, and co-director of the MRMP Stroke Unit, and Dr. Robert Watson, preventive medicine (epidemiology) and medicine (research).

MSMA Supplies HIC Claim Forms

The Uniform Health Insurance Claim Form—a goal in medicine and the insurance industry for more than 15 years—has become a reality in Mississippi with approval by the Mississippi Hospital Association. The state medical association approved the standard form nearly 10 years ago.

The standard claim, now accepted by more than nine out of 10 insurance companies, is a one-page, abbreviated form requiring only nine items of information on diagnosis, treatment, hospitalization, and fees charged. It was developed under the leadership of the AMA and the Health Insurance Council, a federation of major health care insurers in the United States.

The form is approved by AMA, HIC, and in Mississippi by the state medical and hospital associations. Its time-saving value to physicians is in its brevity and uniformity, eliminating the necessity of completing long and individualized forms issued by each insurance company. Studies



Sources of Sinus Headache

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The proved formula of Sinutab which provides triple action – analgesic, decongestant and antihistaminic – is specifically designed for the symptomatic relief of sinus headache and nasal congestion.

INDICATIONS: Sinutab is indicated for the symptomatic relief of headache, facial pain, malaise, fever, nasal and sinus congestion often associated with acute and chronic sinusitis, allergic rhinitis, vasomotor rhinitis, influenza, and the common cold.

ADVERSE REACTIONS: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

DOSAGE: Adults – 2 tablets every 4 hours.
Children (6-12 years) – ½ the adult dose.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Source of Symptomatic Relief

Sinutab® | 2 tabs. q.4h.



WC

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MORRIS PLAINS, N J

have shown that competent insurance clerks multiply productivity four-fold using the standard HIC form in preparing insurance claims.

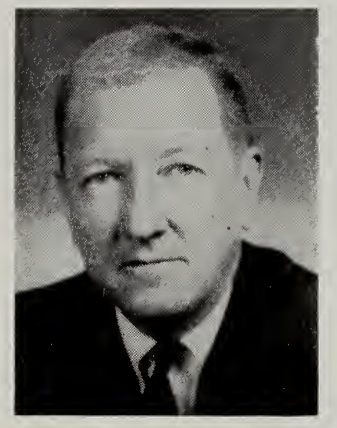
The state medical association supplies pads of the form, bearing the indicia of both the Health Insurance Council and association itself, to members at cost plus postage and handling charges.

Forms are supplied in pads of 25 sets each at 85 cents for a single pad, 82 cents each in lots of five pads, 79 cents each for orders of 12, and 76 cents each for lots of 25 pads or more.

Remittances must accompany orders, because the cost pricing does not allow for billing and bookkeeping expense. Many association members have been regular users of the standard form for years.

AHA Leader Slates Jackson Appearance

"Hearts and Husbands," a special program featuring Dr. Walter B. Frommeyer, president-elect of the American Heart Association, will be presented at the new Jackson Municipal Auditorium on Thursday, Nov. 7. The program is open to the public.



Dr. Frommeyer

Dr. Frommeyer is chairman of the department of medicine at the University of Alabama Medical Center in Birmingham.

Ways in which a woman can help save her husband's heart and life will be discussed. Topics will include cars, exercise, diet, sex and work after a heart attack. Prevention of heart attacks will be emphasized.

The program will also include a panel discussion, followed by a question-and-answer period. Participating will be Dr. Jetson P. Tatum of Meridian, president-elect of the Mississippi Heart Association; Dr. George E. Burch of New Orleans; and Drs. James Hardy and Patrick H. Lehan, both of Jackson, with Dr. Manning Hudson, Jackson, as moderator.

The program is sponsored by the Mississippi Heart Association and by the Jackson Federation of Women's Clubs.

Dr. Frommeyer's years as a scientific member of the American Heart Association include serving as president of the Alabama Heart Association, and seven years on the American Heart Association board of directors.

He has served as vice-chairman of the American Board of Internal Medicine, is a regent of the American College of Physicians, and is a member of the Association of American Physicians, Alpha Omega Alpha and Sigma Xi, medical and research societies, the American Federation of Clinical Research, and the Southern Society for Clinical Investigation.

A graduate of the University of Cincinnati, where he also got his M.D. degree, Dr. Frommeyer took additional training at Cincinnati General Hospital, Thorndike Memorial Laboratory in Boston, and at Harvard Medical School.

As an Army officer in World War II, he earned both the Purple Heart and the Bronze Star with Oak Leaf Cluster.

UPI, AP Overplayed CHAMPUS Story

A wire story by United Press International stating that the Department of Defense had reimbursed 3,500 military dependents some $54,000 which they had previously paid in "overcharges by physicians" grossly overstated the government action, spokesmen for the Mississippi State Medical Association said.

The American Medical Association has pointed out that the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), formerly the original military Medicare, pays 80 per cent of usual, customary, and prevailing charges for outpatient services to dependents of active duty personnel and 75 per cent of such charges for the retired.

In some instances, AMA stated, the beneficiaries are inadequately informed as to their own responsibilities, and the payment was a reimbursement for the portion which they did not previously know that they had to pay. Other reimbursements were for charges which CHAMPUS fiscal administrators could not entertain as usual and customary and which had been paid in full by the beneficiary.

AMA described the incident, also reported by the Associated Press, as a "tempest in a teapot." As administrator for professional service aspects

of the program in Mississippi, the association is currently paying 94 per cent of physicians' claims as billed under the concept of usual, customary, and reasonable fees.

Vacuum Curettage Will Help in Gyn

Complete equipment for vacuum curettage is now being offered for hospital use by the Bio-Engineering Division of Berkeley Tonometer Company.

The VC-II vacuum collection system supplies the necessary conditions for uniform and successful emptying of the gravid uterus by suction. A vacuum level well below the boiling pressure of aspirated fluids coupled with the highest throughput available makes the Berkeley VC unit optimum for removal of the products of pregnancy, incomplete abortion cleanup and removal of the hydatidiform mole.



New vacuum curettage unit, left, is shown with autoclavable vacuum hose and vacurette tips.

Explosion-proof elements allow its use with all anesthetics. The collection bottle heads allow separation of solid from fluid products by using replaceable gauze tube bags on the specially designed entrance spout.

Oilless operation of the explosion-proof pumping system means continued readiness for use without overhaul and breakdown interruption. Series trapping protects the pump without impairing safety, collection volume, or pumping effectiveness.

The system is delivered complete with a nine foot plastic, autoclavable vacuum hose, autoclavable swivel handle with integral vacuum control and three Vacurettes.

All connections are made with quick, easy-action machined fittings. Cleanup and maintenance problems are minimized by hospital personnel-oriented design throughout.

In addition, provision has been made to allow simple add-on attachment of the Berkeley Vibrodilator unit. This rapid cervical dilator is expected to be offered to the profession in November.

Vacurettes, made of clear crystal plastic, offer functional design with the thinnest possible walls. Dilatation is accomplished at least one Hegar size smaller for a given lumen size.

Berkeley's freely rotatable Vacurette handle permits the high VC vacuum level to be dropped to atmosphere with a small, effortless finger movement—something impossible with a small occludable orifice in the side of the tubing pipes occasionally used for this purpose.

The use of Vacuum Curettage is expected to result in reduced risk, blood loss, anesthesia, and expense to the patient.

AMA Seeks Auto Accident Data

Teams of physicians and police traffic officers have been proposed as a means of collecting vitally needed scientific data from auto accidents.

Dr. H. A. Fenner, Jr., of Hobbs, N. M., chairman of the American Medical Association's Committee on the Medical Aspects of Automotive Safety, pointed out that every traffic accident presents an opportunity to discover clues to prevention.

"Most accident reports at the present," Dr. Fenner said, "are related to law enforcement rather than to research-oriented data collection.

"If we had a corps of knowledgeable, trained, and qualified physicians and police officers to provide accurate, scientific reports on a large number of accidents, automotive engineers would have the necessary data to translate into safer motor vehicles and highways."

Dr. Fenner noted that many of the safety devices on present-day automobiles and highways resulted from traffic accident research.

According to Dr. Fenner, the AMA committee, along with the American Association for Automotive Medicine, is studying the possibility of working with one or more universities in the establishment of intensive courses in accident investigation.

Preliminary discussions have indicated that such a course would be of three days duration and would be limited to 200 teams, each con-



Geigy

sisting of a physician and a member of a police traffic department.

Dr. Fenner said the important need at the moment is to determine if enough physicians are interested in participating in such an effort.

Physicians who are interested in participating are asked to send their name, address, age, medical college, and field of practice to the Committee on Medical Aspects of Automotive Safety, AMA, 535 North Dearborn, Chicago, Ill. 60610.

Lowndes Auxiliary Gives Book Cart

Members of the Lowndes County Medical Auxiliary jointly contributed a book cart and display rack to the Magnolia Manor Nursing Home at Columbus. Cooperating in the effort was the Lowndes County Library System.

The presentation, including a memorial book in honor of the home's first patient, the late H. H. McClanahan, Sr., father of Dr. H. H. McClanahan, Jr., of Columbus and past chairman of the state medical association's Board of Trustees, was made by Mrs. H. H. McClanahan, Jr., and Mrs. Douglas Bateman, respectively representing the Auxiliary and library system.

The county library system supplies books and periodicals to hospital and nursing home patients, including large-print publications and "talking books" for those with sight difficulties.

Coast Group Holds Medicine-Sports Meet

The professional staff of the Howard Memorial Hospital at Biloxi sponsored a conference on athletic injuries which was attended by more than 40 coaches and team physicians. Co-sponsors included the Bel-Bru Sporting Goods Co. of Biloxi, the Sportsman's Corner of Gulfport, and the Coast fellows of the American College of Surgeons.

Drs. Jerry R. Adkins and Archie C. Hewes served as moderators for the meet. Appearing as essayists were Drs. Daniel L. Hollis, Robert Erwin, William Everett, and Clay Easterly.

Discussion topics analyzed 24 fatalities attributable to football during 1967 and also covered such subjects as heat prostration, head injuries, knee and ankle mishaps, soft tissue injuries, and resuscitation.



THE BRADLEY CENTER

An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

Brochures and rate schedules are available on request.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen.(Ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 - 324-4882

Alabama RMP Names New Director

Dr. John M. Packard, of Pensacola, Fla., has been appointed director of the Alabama Regional Medical Program, to be in charge of all medical and professional aspects of projects to be developed under this Program. The announcement of Dr. Packard's appointment was issued recently by the Medical Center of the University of Alabama in Birmingham, in a statement by Dr. Benjamin Wells, Program coordinator of the ARMP, and Dr. S. Richardson Hill, Jr., dean of the Medical College of Alabama.

Dr. Packard will assume his new duties on Jan. 1, 1969.

A great part of Dr. Packard's attention will be given to the development of continuing education of physicians, according to Dr. Wells. "He will bring to the Regional Medical Program of Alabama the leadership qualities and experience most needed to achieve a practical working relationship between the Medical Center in Birmingham and practitioners throughout the state. This is a fundamental objective of the Program. Dr. Packard will work closely in all of these activities with Dr. J. O. Finney, associate director of the Program."

Dr. Packard had a leading role in the development of the Pensacola Educational Program, a cooperative venture in which three community hospitals in that city have united their efforts since 1961 to operate an internship and residency program. The hospital group has employed a director of medical education who coordinates the teaching activities of all three institutions. The Pensacola program has been conducted without support from any governmental source and without formal affiliation with any university or medical school.

"Despite these difficulties," Dr. Wells said, "the program has won national acclaim for its striking success as a community-based project for graduate medical education."

In announcing Dr. Packard's appointment, Dr. Hill said, "The Alabama Regional Medical Program is extremely fortunate to secure the services and leadership of a physician who is strongly identified with excellence in the practice of medicine and with continuing education at the community level."

TAO®(triacetyloleandomycin)

Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires reevaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.



J. B. ROERIG DIVISION
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NEW YORK, N.Y. 10017

Tuberculosis Monitor Is Developed in Georgia

The Medical College of Georgia and the National Cash Register Company together have developed a computerized system for monitoring and analyzing the incidence of tuberculosis and other communicable diseases within a given state or smaller community. The system is the product of two man-years of programming effort.

Under the direction of Dr. Rufus F. Payne, the Medical College's Division of Hospital Research and Development is actively exploring the application of the computer to the solution of medical problems. Current projects include:

—The development of a medical audit system for hospitals. Under this system, the computer will analyze the utilization of facilities, the quality of care, the value of established procedures, the effectiveness of antibiotics under different conditions, the normal delays in making space available for different groups of patients, and so on.

—The development of computerized medical records for out-patients of a hospital or large clinic. These records will provide any staff doctor or dentist who must refer to them a current and comprehensive picture of the patient's condition. The investigation is expected to reveal what the format of the records should be, how frequently they should be printed out by the computer, and whether the costs of maintaining such records can be justified. At the present time, the study is concentrating on the records of pediatric and pre-natal patients.



Dr. Payne and Bradley Roark, NCR's medical services representative, study control program documentation to eliminate final flaws before processing live data.

—A complete patient information system for hospitals, a long-range, large-scale project that will include many sub-projects.

—A control system which is designed to be used in long term management of any type patient but is particularly useful in communicable disease control. Of the four projects this one has been the most thoroughly tested and is currently in operation in Richmond County (Augusta), Georgia, and Aiken County (Aiken), South Carolina, with records now being abstracted for the inclusion of patients in other nearby counties.

Under the system, every person who is identified by a doctor or a clinic or other source as having experienced some degree of risk, either in terms of contact or of actual disease, is registered by the Control Registrar. The basic information on each patient is written in a standard form which organizes it for entry through series of punched cards into the computer. The process of filling in the form requires about two minutes for a new case and an average of ten minutes for a case with a treatment history. This information is stored in the computer's magnetic file for regular review and analysis.

The computer prepares new case and contact report lists and investigation requests on a weekly basis. These listings, broken down by locality, are sent to field investigators, public health nurses and others responsible for locating and investigating new cases.

After a case has been entered into the system, action is begun to cure the patient and protect his contacts. Appointment letters, informing the patient and the contacts that they are scheduled for an examination, are written by the computer. These may be either the initial examination letter or periodic reminders of regular check-ups once the patient begins treatment. As the letters are written, schedules are established for the various treatment centers.

The scheduling of the facilities is completely maintained by the system with allowance for STAT changes by physician, lab, or clinic. All data pertinent to examination, treatment, and drug scheduling is stored in the magnetic files. If the forms provided to the clinic for the recording of test results, treatments, and drug prescriptions. are not returned within the stipulated time, the system reports the patient as delinquent.

Under a manual system, the scheduling of tests and examinations is ordinarily a tedious operation requiring the attention of a medically competent individual, usually a doctor or a nurse. A TB nurse may spend 20 per cent of her time reviewing records.

Under this electronic system, the computer can

review and update 500 patient records—including the preparation of schedules and the writing of the appointment letters and reports on the 500 patients—all within 12 minutes. The system frees the doctor or nurse for more demanding medical functions. Furthermore, the computer applies a rigid set of criteria to produce consistent results under all conditions.

New Blue ID Helps 'Usual and Customary'

Physicians and their office assistants will be seeing more patients carrying Blue Shield's new identification card designed for subscribers in certain "national account" groups.

This new national account ID card is being given to employees of large national organizations whose employees are located in different areas of the country, involving a number of Blue Shield plans.

The card for national accounts looks somewhat different from the type issued by a local Blue Shield Plan. It carries the words "Blue Shield Identification Card" across the top and the words "National Account" printed over the silhouette of a map of the United States.

When the medical office provides professional services to a patient carrying one of these Blue Shield national account cards, the regular claim form should be completed and filed with the local Blue Shield Plan.

This is particularly important for determining usual and customary fees for subscribers having this type of benefit program. Only the host Blue Shield Plan can determine a proper allowance for physicians' services within its area.

Use of the new card will help to expedite the processing of claims by facilitating the determination of a subscriber's eligibility for benefits. In addition, such a card will preclude the necessity of re-issue of ID cards when employees move from one Blue Shield area to another.

This national account card is used in combination with central certification, an administrative system devised by Blue Shield and Blue Cross, to provide certain national buyers of health coverage with a uniform set of benefits and to give the providers of care a means of identifying eligible subscribers from outside the local area.

Medical and hospital benefits for employees are uniform within centrally-certified groups, regardless of where the individual employee may be located.

USPHS Organizes Administrative Curriculum

A grant of $260,000 has been awarded by the U. S. Public Health Service to Ithaca College (N. Y.) to pioneer a four year course of study in health services administration.

According to a leading educational consultant, the program is the only one of its kind in the country at the bachelor's degree level and it is designed to meet the increasing demand for highly trained administrators of medical care services.

Dr. Stephen M. Schneeweiss, an associate professor of health education at Ithaca College, is director of the new curriculum which will emphasize health and business administration from a base in the arts and sciences. About 50 high school seniors will be allowed to enroll in the program which begins in Sept., 1969.

While the entire $260,000 has been set aside for the new curriculum at Ithaca College, the grant is conditional and the project is subject to annual review by the Public Health Service. The funds are earmarked for program development costs during the next five years.

According to Dr. Schneeweiss, a graduate of the program would first serve as an assistant administrator in a health service center. After further educational or professional experience he could become an executive of a voluntary health agency, an administrator of a governmental health agency, or an administrator of hospitals, nursing homes or other patient care health activities.

"The curriculum will be strong enough to be the base for further graduate study in health administration or medicine," Dr. Schneeweiss said. "No program exists at the baccalaureate level today to train persons in the administration of health services and still permit them to continue on to higher degrees within the field without undue difficulty," he added.

Ithaca College will graduate its first class in 1972. "This is going to be a great help to hospitals where, in many cases, the position of administrator is held by physicians, nurses or other trained professionals. Our graduates will free these persons and allow them to take leadership positions in professional areas where they are so badly needed," Dr. Schneeweiss said.

Dr. Schneeweiss believes that well-trained health service administrators will also help reduce cost to medical consumers.

The new curriculum at Ithaca College is the product of 18 months cooperative effort by Dr. Schneeweiss, the faculty, and the administration of the College. Leading figures of the nation's



"Upper respiratory infection! I thought everything was a 'virus' these days?"

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

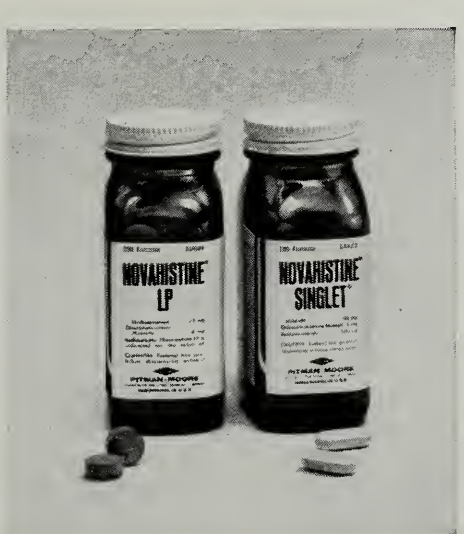
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



Dow PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

health care industry will assist Dr. Schneeweiss on an advisory council during the program's formative years.

Dr. Schneeweiss, 32, earned his bachelor's degree and master's degree at Hunter College of the City University of New York. His doctorate in Administration of Health Education was earned at Columbia University.

This year, administrative details of the program will be worked out and students will be recruited. During the four years of the degree program, six full time instructors will be added to the faculty and a summer internship program will be effected. Students will spend two eight-week periods working in hospitals, health care agencies and nursing homes.

SKF Reorganizes Instrument Subsidiary

Smith Kline & French is consolidating its medical instruments operation into one subsidiary company to be located in Palo Alto, California, it was announced today.

Corbin-Farnsworth, Inc., of Palo Alto, SK&F's cardiac monitoring and resuscitation equipment subsidiary, will combine with Smith Kline Instrument Company, of Philadelphia, manufacturer of specialty medical instruments, to form Smith Kline Instruments, Inc.

Thomas M. Rauch, president and chief executive officer of SK&F, Philadelphia manufacturer of prescription drugs and other health-related products, said consolidation should be completed by October 1, 1968.

"The move will accommodate future growth and expansion and increase operating efficiency," Mr. Rauch said. "We are most enthusiastic about this consolidation, which, in essence, is a concentration of our effort and an expression of our confidence in the medical instrument business.

"We are convinced that Smith Kline Instrument's ultrasonic diagnostic instruments as well as the new 'Eskalab' Clinical Chemistry System and Corbin-Farnsworth's monitoring and resuscitation equipment are the finest of their kind. The consolidation represents intensified focus on medical fields in which we believe SK&F and Smith Kline Instruments, Inc., have a bright future."

The new company will take advantage of Corbin-Farnsworth's major new facilities at the Stanford Industrial Park and their proximity to important research associates. The Palo Alto site also will be close to the major supplier of the chemical reagents used in the 'Eskalab' system.

Emphasis on SK&F's medical instruments development will be further buttressed by a combined marketing force which will enable Smith Kline Instruments, Inc. to apply greater flexibility to its several areas of interest. The names Corbin-Farnsworth and Smith Kline Instrument Company will continue to be used in the marketing of existing products.

Lawrance A. Brown, Jr., director of the now discontinued Medical Instruments Division, will become President of Smith Kline Instruments, Inc. Elliott C. Farnsworth, formerly president of Corbin-Farnsworth, will be Executive Vice President of the new company and Thomas H. Corbin, executive vice president of Corbin-Farnsworth, will be Vice President, Technical Operations.

"The medical instruments consolidation is a good example of SK&F in transition—stepping forward to meet the challenge of tomorrow, today," Mr. Rauch said.

"The environment and conditions under which we operate are changing, and the character of our corporation is changing, too. From a prescription specialty house with major marketing emphasis in the United States, SK&F has become a multi-product, international company moving toward ever greater diversification and growth inside and outside the U. S.

"To achieve this objective, we intend to continually appraise all aspects of our operations and seek out and evaluate opportunities for new ventures and acquisitions, developing those with the most promise."

Tumor Registry Has Backing in Law

A last-minute enactment of the 1968 Regular Session of the Mississippi Legislature, already signed into law by Governor John Bell Williams, will provide a legal basis for establishing a statewide tumor registry. The principle involved in the law was approved by the association's Board of Trustees prior to enactment.

Sponsor of the measure was Rep. Russell Davis of Hinds County. Dr. Guy T. Gillespie. president of the Mississippi Division, American Cancer Society, provided active leadership in securing passage of the bill.

Under the terms of the enactment, the tumor registry may make use of patient identity without liability, thereby assuring accuracy of case identification and elimination of duplication.

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JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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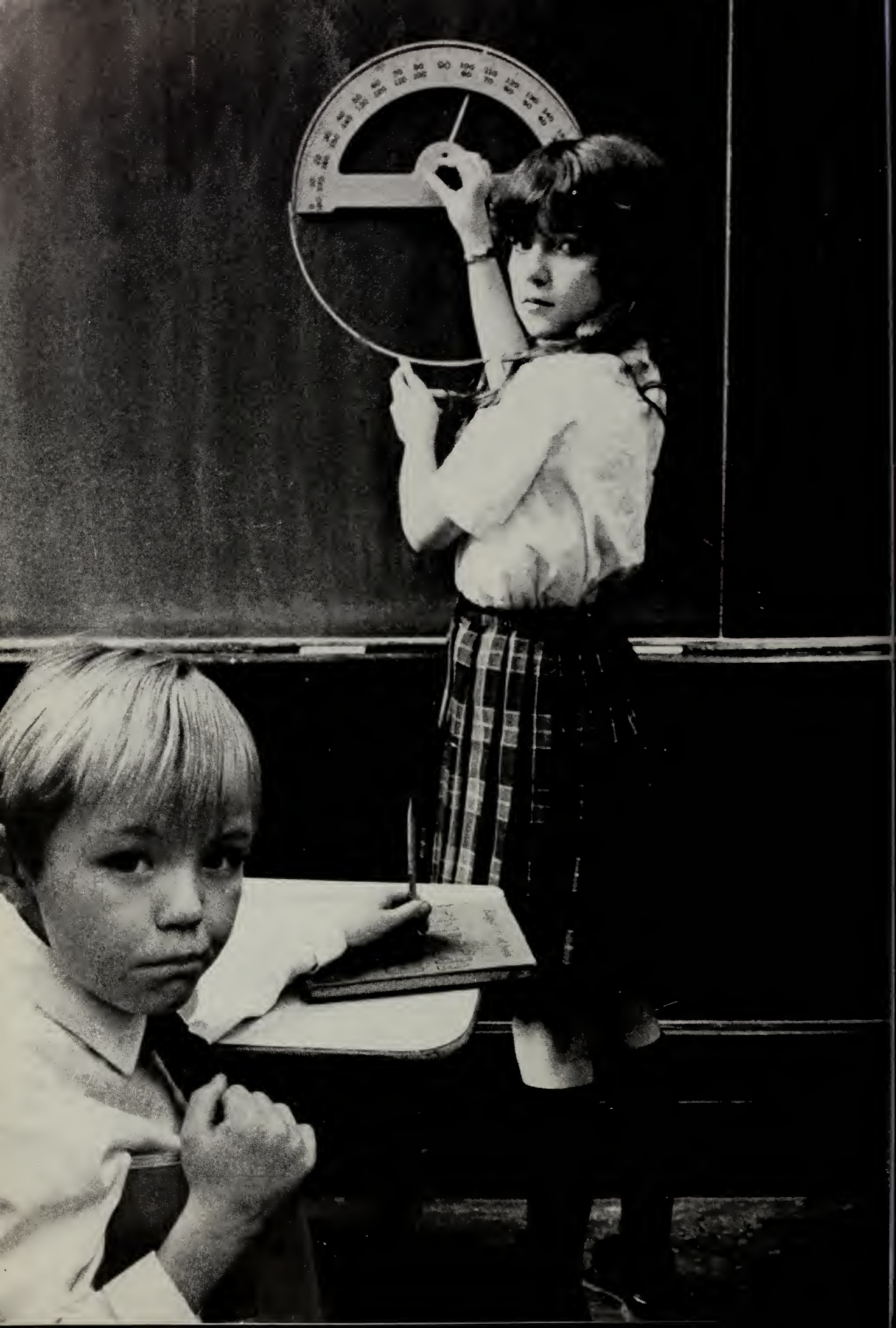
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NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION
JACKSON, MISSISSIPPI

November, 1968

Dear Doctor:

Four Mississippi cities are among more than 100 U.S. communities said by McCall's Magazine to have substandard water supplies. Included are Meridian and Natchez as "needing improvement" with more bacterial checks and Pascagoula and Vicksburg as being "unsatisfactory" with high bacterial counts.

> State Board of Health spokesman told Journal that article is a half truth on Mississippi. Supplies are acceptable and water systems are being improved. McCall's said data were furnished by U.S. Public Health Service for article.

Admission of over-65 patients to American hospitals is up more than 10 per cent over last year, as Medicare gains impetus. Health Insurance Institute reports that one of five inpatients is over 65 and that studies made in July show mean cost of $67 per patient day.

A new and promising program to upgrade professional attainment has been instituted by the American Society of Anesthesiologists. ASA adopted a proposal by American College of Anesthesiologists to develop a self-evaluation program for members in cooperation with National Board of Medical Examiners. Costs will be met by fees charged for examinations.

The Department of Defense has published for the first time standards for quality and packaging of drugs purchased for the military. DOD has always used quality measures, but these were not formally published. New standards are flexible, recognizing continuing advances in drug making and packaging.

A third of the nation's certified radiologists teach in medical schools, according to a survey by American College of Radiology. Study showed that average medical school department of radiology had 12 full-time instructors and 19 part-time teachers. This projects to nearly 2,500 radiologists directly involved in medical education.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Medicare Reports High Administrative Costs

Baltimore - The Social Security Administration says that it cost nearly a quarter billion dollars to administer the Medicare program for the last fiscal year. Part 1-A, hospital and related services, overhead ran $79 million, about 2.1 per cent of the $3.7 billion paid in benefits. Part 1-B, medical services, cost $143 million to administer, a high 9.5 per cent. Big difference is that 13 million hospital bills were processed against 46 million medical service bills.

MHA Survey Shows Hospitals Collecting For Physicians

Jackson - A survey by the Mississippi Hospital Association disclosed that 23 of 69 responding hospitals actually collect the physician's fee in his behalf for outpatient services rendered in ER. Twenty-seven of 66 hospitals prepare health insurance and voluntary prepayment claims for physicians who have rendered care to inpatients. Combined, projected findings seem to indicate that 40 per cent of hospitals are involved in some degree in professional fee collections.

Staff Privilege By-Laws Are Held Invalid

Mobile - A federal appellate court has ruled that the Mobile County Hospital's by-laws requiring membership in the county medical society as a prerequisite for staff privileges are invalid and violative of equal protection under the 14th Amendment. Two plaintiff physicians, not society members, were successful in suit to enjoin hospital board from denying staff membership. Citation is Foster v. Mobile County Hospital, F. 2d (C.A. 5, June 24, 1968)

CPI Lists 1967 Care Cost Increase

Washington - The U.S. Bureau of Labor Statistics reports that overall health care costs increased by 7.0 per cent in 1967. By components, physicians' fees were up 7.1 per cent; dentists' fees, up 5.0 per cent; hospital charges, up 19.1 per cent; and prescription drugs, down by 1.8 per cent. Data are in Consumer Price Index which says that increased demands upon a fixed supply of health care resources and increased public purchasing power largely accounted for increases, except for factor of mounting hospital labor costs.

Firearms Deaths Occur Mostly In The Home

New York - Studies by Metropolitan Life Insurance Co. reveal that 60 per cent of firearms fatalities, 1,500 of 2,600 such deaths annually in U.S., occur in the home when cleaning or playing with weapons. Over half of deaths are from rifle or shotgun accidents, but Russian roulette with revolvers accounted for 4 per cent of fatalities.



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Throwaway Lung May Help Newborn

Long-term maintenance of blood-oxygen levels in newborn infants suffering from respiratory distress syndrome may soon become a practical clinical reality with a new artificial lung developed by scientists in the National Heart Institute, a component of the National Institutes of Health.

The NHI scientists, and collaborating scientists in Boston, Chicago, and Baltimore report their use of the highly efficient and disposable membrane lung to safely maintain adequate blood oxygen levels in newborn lambs during continuous use for periods of up to four days (96 hours).

These findings have just been published in the *Transactions of the American Society for Artificial Internal Organs,* by Drs. Theodor Kolobow and Warren M. Zapol of the NHI's Laboratory of Technical Development, Joseph E Pierce, NHI Laboratory of Kidney and Electrolyte Metabolism, Ambrose F. Keeley, Boston City Hospital, Robert L. Replogle, University of Chicago Medical School, and J. Alex Haller, Johns Hopkins University School of Medicine.

Heretofore, prolonged blood-oxygenation with an artificial lung has been limited in duration to less than 12 hours in newborn laboratory animals, and has been accompanied by severe damage to lungs, blood cells and blood proteins, as well as the formation of dangerous blood clots and air bubbles in the blood.

The cylindrical, pint-sized lung, called the "spiral coil membrane lung," contains a thin (5/1000 inch) silicone rubber membrane formed into a flat tube or envelope that is wound about a central spool. The envelope is fitted with oxygen inlet and outlet ports. Blood enters one end of the lung's cylindrical housing, flows between layers of the spirally-wound silicone envelope and, still flowing parallel to the cylinder's axis, exits at the other end. As in other membrane lungs, blood oxygen and carbon dioxide exchange occurs by diffusion across a membrane. However, unlike most membrane lungs, the spiral coil lung is suction-actuated, i.e., oxygen is pulled through the lung by the intermittent application of a slight vacuum to the oxygen outlet port.

The new lung owes most of its safety advantages as well as its high oxygenating efficiency to this gentle, cyclic application of negative pressure, as it prevents oxygen bubbles from entering the blood (gas emboli) should pin hole leaks occur in the membrane, and the pulsatile motion it imparts to the membrane greatly increases blood oxygenation by eliminating the "stagnant" boundary lay-

er of oxygen-saturated blood immediately adjacent to the membrane. Thus, more blood is brought into contact with the membrane where oxygenation occurs. Finally, the low perfusion pressure and pulsatile motion, along with normal arterial blood pressure, act to propel blood through the lung and eliminate the need for a separate blood pump with its attendant damage to fragile blood components.

Performance of the spiral coil lung was studied during prolonged use in eight newborn lambs (from one to eight days old), each connected to an externally located spiral coil lung by means of plastic tubing inserted into an artery and a vein in the neck. Lambs were chosen for these studies because they weigh about the same as newborn infants. In these studies, oxygenating efficiency of the artificial lungs were determined daily during brief periods of oxygen lack when the lambs were subjected to an atmosphere containing only 7 per cent oxygen.

The NHI and collaborating scientists report that the artificial lungs performed well during continuous operation in the animals for periods of from 21 to 96 hours, and that no consistently abnormal gross or microscopic changes occurred in the six survivors.

From this excellent performance of the spinal coil lung, and the overall benign affects of its prolonged use in animals, the scientists feel that its use should be considered as a method of treating respiratory distress in the newborn infant or adult. The spiral coil lung can oxygenate up to 450 cc. of blood (nearly a pint) per minute, yet has a total priming volume of only 45 cc.

Coast Gives Drugs for South Vietnam

A team effort among Coast units of the Woman's Auxiliary, Gulfport Jaycettes, local physicians, and the Naval Construction Battalion Center (Seabees) is paying off handsomely in drugs for the civilian population of war-torn South Vietnam.

Working on three-month cycles, the program is collecting an average of 300 pounds of drug samples from physicians four times yearly. The Medical Auxiliary and Jaycettes gather the drugs which are classified and sorted under pharmaceutical supervision.

The samples are crated and shipped to South Vietnam for use in villages, orphanages, and civilian clinics under the Seabees Civic Action Program.



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AHA Publishes Infection Control Book

What the hospital worker must know to prevent and control infection within his institution is provided in a comprehensive handbook just published by the American Hospital Association.

Entitled *Infection Control in the Hospital,* the 140-page publication is intended to be a handy reference from which the hospital worker on the job can readily obtain the information he needs. The AHA Committee on Infections Within Hospitals compiled and evaluated all available currently useful information on the subject and presented it as succinctly and explicitly as possible in the text.

While it was not possible to treat each facet of infection control in great detail, the manual attempts to present the essential features of each facet of the problem, and to point out significant interrelationships.

The publication covers such areas as the epidemiology of infection, individual and organizational responsibilities, prevention and control, special problems, the establishment of an infection control committee, a surveillance and reporting program, employe health service, employe education programs and regulations for hospital visitors.

Copies may be obtained for $3.75 each from the American Hospital Association, 840 North Lake Shore Drive, Chicago, Ill. 60611.

UA Names New Chairman of Medicine

Dr. T. Joseph Reeves, professor of medicine and director of the Cardiovascular Research and Training Center, University of Alabama Medical Center, will assume the chairmanship of the Department of Medicine, Medical College of Alabama, on Jan. 1, 1969.

Announcement of the appointment was made today by Dr. S. Richardson Hill, Jr., Dean of the Medical College, and Dr. Joseph F. Volker, Executive Vice President, University of Alabama in Birmingham, and Director of the Medical Center.

"We are immensely fortunate to have a man of Dr. Reeves' caliber to succeed Dr. Frommeyer as chairman of the Department of Medicine," Dr. Hill said. "His qualities of leadership and professional ability have been evidenced by the development of our superior cardiovascular programs

(Turn to page 18)



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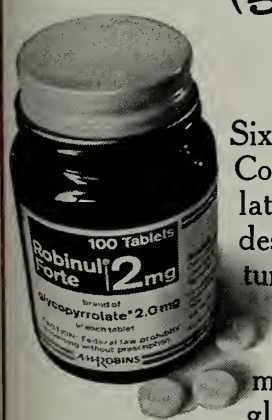
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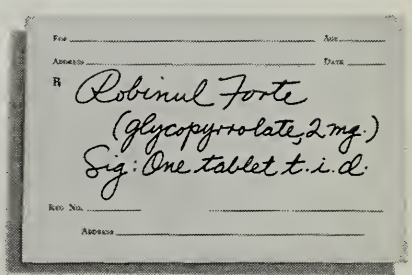
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Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

(Continued from page 15)

in which he has a major role. Certainly the Department of Medicine will continue to grow under his guidance."

Dr. Reeves has also held the Alabama Heart Association Chair of Cardiovascular Research since it was established in 1966, but will relinquish this position. He will continue to lead the Cardiovascular Research and Training Center.

The CVRT Center, one of the nation's largest such programs, is a comprehensive effort to combat diseases of the heart and circulatory system. It involves many scientific disciplines and encompasses studies from basic biologic and physical science levels to clinical investigations in research laboratories, the operating room and at the bedside of patients suffering from cardiovascular diseases.

"Dr. Reeves is internationally known for his clinical abilities and his major contributions to the knowledge of cardiovascular diseases," Dr. Volker said. "He is one of the Medical Center's most distinguished faculty members and is an excellent choice for the chairmanship of the Department of Medicine."

Dr. Reeves joined the Medical Center faculty in 1954 and was made professor of medicine in 1960. He was appointed director of the Division of Cardiology in 1965 and held this post until 1966, when he accepted the Alabama Heart Association Chair of Cardiovascular Research. He became director of the Cardiovascular Research and Training Center in 1967.

Dr. Reeves is a member of the American Society for Clinical Investigation, Association of American Physicians and the American Physiological Society, as well as numerous other medical groups. He is a fellow of the American College of Physicians and a Diplomate of both the American Board of Internal Medicine and the American Board of Cardiovascular Diseases. He is a member of the National Advisory Committee for Heart Disease Control, Bureau of State Services, Department of Health, Education and Welfare; and served as chairman of the National Heart Institute's Program Project Committee, a major research review committee of the NHI.

Dr. Reeves received his M.D. degree from the Baylor University College of Medicine in 1946 where he was a member of Alpha Omega Alpha honor society. He studied at the Medical College of Alabama in 1951-52 on a National Heart Institute Traineeship and later held a special postdoctoral fellowship of the NHI at Queen Elizabeth Hospital in Birmingham, England. He served as chief of medical services at the Birmingham, Alabama, Veterans Administration Hospital from 1954-55.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
November 1968, Vol. IX, No. 11

ORIGINAL PAPERS

Chemotherapy for Ovarian Cancer

RICHARD C. BORONOW, M.D., and
WARREN N. BELL, M.D.
Jackson, Mississippi

While ovarian cancer is the third most frequent gynecologic malignancy, it ranks number two in mortality because the curability rate is so low. The authors discuss diagnosis and treatment. They conclude that there does appear to be a group of ovarian cancer patients who will be benefited by chemotherapy. They observe, however, that it is necessary to pursue all aspects of available techniques permissible by medical and ethical consideration.

MOST PHYSICIANS are accustomed to thinking of ovarian cancer as the third most frequent gynecologic malignancy with cancer of the cervix first, and endometrial cancer second. However, the curability of ovarian cancer is so low that it ranks number two in mortality. American Cancer Society statistics suggest about 9,000 American women will die of ovarian cancer this year; about 4,000 of endometrial cancer; and about 10,000 of cervix cancer.[1] As earlier diagnosis and better primary therapy combine to drive the cervix cancer death rate down still further, ovarian cancer may indeed emerge as the number one killer among gynecologic cancers.

Surgery is essential for diagnostic purposes. However, it is not often curative because, by virtue of the silent progress of the disease, most series report from 50 to 75 per cent in the unresectable stages when they are first seen.[2] Dissemination is first by surface spread. Thus, even the lesion confined to one ovary but with papillary excrescences on the capsule, is at least theoretically disseminated. Enthusiastic pelvic dissections in the presence of extensive involvement, even with the greatest technical skill, have failed to prove beneficial.

Radiation therapy has been of limited value but has seemed to add an additional small measure of control. There has been controversy as to (a) the high dose total pelvis techniques versus (b) lower dose, larger volume techniques, such as total abdomen. Total abdomen techniques generally reach a tolerance at about 3,000 r and this dose is generally not cancerocidal. Radiation to the total pelvis may be cancerocidal when pushed to the 4,000 to 6,000 r level, but, of course, does not treat gross or microscopic extrapelvic spread, nor the lymphatic drainage of the ovary by way of the infundibulo-pelvic ligament to the common iliac, aortic, and lumbar nodes.

The challenge to cure ovarian cancer has not yet been answered. Gusberg suggested some years ago that the best way to improve one's survival figures was to get a more liberal pathologist.[3]

From the Departments of Obstetrics-Gynecology and Clinical Laboratory Sciences, University of Mississippi School of Medicine.

The most hopeful of modalities presently available is systemic chemotherapy. Modern chemotherapy was born about 25 years ago with the use of nitrogen mustard in the lymphomas. With regard to ovarian cancer there was a well-recognized palliative benefit in malignant effusions from nitrogen mustard. Nitrogen mustard also was employed systemically. A variety of mustard-like compounds (the alkylating agents) have been synthesized for systemic use. This era is about a decade old. A flurry of papers appeared in 1959. Green reported 19 cases treated with hemisulfur mustard intravenously with apparent benefit to 79 per cent of cases.[4] Masterson and associates, using chlorambucil, reported 30 patients or 67 per cent were favorably influenced.[5] Coonrad and Rundles gave alkylating agents to 38 patients and 50 per cent were favorably affected for periods from four months to six years.[6] Bateman reported 31 per cent of her series lived five years after demonstrable metastasis and therapy with Thio-TEPA.[7]

In these intervening years, enough series have accumulated to permit some tentative answers to a few important questions:

1. Does systemic chemotherapy actually influence ovarian cancer?
2. What per cent of patients will be benefited?
3. What are the standard criteria for response?
4. Will patients be cured?
5. What drug is best?
6. What dosage is best?
7. Is the combination of irradiation and chemotherapy superior?

In attempting an objective answer to these questions by searching the reports published in these past years, one often finds a strong thread of enthusiasm. In instances where these papers have been formally presented and discussed, one often finds in the discussion a thread (occasionally strong) of skepticism. Objectivity is not enhanced by either skepticism or enthusiasm.

OBJECTIVE ANSWERS

Question 1. Does chemotherapy influence ovarian cancer? Certainly, in the germinal epithelial tumors, which are the common ovarian cancers, there is a definite response rate. This seems most apparent in the serous adenocarcinomas.

Question 2. What per cent of patients will be benefited? Ranges in reports from 15 to 80 per cent response rate are difficult to explain if one does not first consider question 3.

Question 3. What are the standard criteria for response? This is most difficult. It involves recognition of an objective response such as decrease in palpable mass or decrease in the rate of reaccumulation of effusions, and these observations are defined in various ways; such as, "a definite decrease" or "25 per cent decrease" or "a 50 per cent decrease." Some say all masses and/or all effusions must respond similarly; others say a single mass or other parameter must respond while the others either respond a little or at least remain unchanged. Another aspect is duration of response. Some do not require a specific duration of time, others require from one to six months. Thus, the lack of consistency of the criteria for objective response explains the lack of consistency in the reported incidence of response. Response occurs; the per cent of "responders" then depends largely upon the qualitative and quantitative parameters one applies to the definition of response.

CURE POTENTIAL

The next question is—will patients be cured? Experience with choriocarcinoma certainly, and also in cases of acute lymphocytic leukemia, Wilms' tumor, neuroblastoma, retinoblastoma have shown that cure with cancer chemotherapy is possible. In most other diseases known to respond to chemotherapy, the response is temporary and relapse, after varying intervals of control, is the rule. There have been reported impressive cases of apparent total control.[8] It remains to be seen if true cures will result.

Actually, the ultimate criteria for response is prolonged survival. If prolonged survival is not demonstrated, then objective response becomes important only as it relates to subjective response. For the therapeutic goal is prolongation of useful life and relief of suffering, not simply prolongation of suffering. Thus, it has become practical as well as academic to ask if chemotherapy responders live longer than non-responders. The answer appears to be yes, dramatized by occasional prolonged control, but probably averaging at present about six extra months.[8, 9]

The next question relates to the drug of choice. Thio-TEPA and chlorambucil were among the early alkylating agents to receive wide trial. Chlorambucil appears to be better tolerated. Cyclophosphamide is also well-tolerated and is rather widely employed. L-phenylalanine mustard has been studied primarily at M. D. Anderson Hospital. It would appear that all alkylating agents have comparable potential value. In addition, the potent but toxic antimetabolite 5-fluorouracil appears to have a place in this disease.

The last question relates to the optimal dose of drug employed. Almost all authors employ a drug dosage that pushes the patient to toxicity. The differences in therapeutic approach lie chiefly in the difference in the drug-dose-time interval. Daily maintenance therapy requires careful checks of parameters such as the white blood cell count and the platelets in order to stay close to continual toxicity. If such determinations are not made frequently and the dosage adjusted accordingly, one then must adopt a more relaxed "safe" dose that is less likely to challenge marrow toxicity (and marrow toxicity is the most usually employed method of evaluating toxicity with the alkylating agents). Thus, one must ask what is "maintenance" therapy. Is it maintenance of near toxic levels (which we generally equate with tumor effect) or is it maintenance of safe non-toxic levels? The relative merits of the two concepts—shortburst courses of therapy (for example, monthly) versus maintenance therapy daily—have been debated. It does appear increasingly clear, particularly from the experience with childhood leukemia, that intensive courses of therapy are superior. Successful treatment of choriocarcinoma is also with short courses of high-dose therapy. We think this is the direction for ovarian chemotherapy.

RADIATION AND CHEMOTHERAPY

There is one final question. Is a combination of radiation and systemic chemotherapy superior? A study by Miller and Brenner in 1962 suggested there was a distinct advantage of total abdomen radiation and systemic chemotherapy.[10] Conversely, in 1964 the University of Wisconsin group found no benefit from combination radiation and systemic chemotherapy.[11] Subsequently, a progress report of a continuing study from the Mayo Clinic suggests that there may be some advantage to such a combination therapy.[12] The final answer clearly awaits further clinical study.

Since January 1956 the Tumor Registry of the University of Mississippi Medical Center and Hospital has recorded 156 cases with ovarian cancer. These records have been reviewed in detail. Because of documented or possible associated second primary cancer, 32 cases were excluded. The remaining 124 cases were retrospectively staged according to the recommended staging of the International Federation of Gynaecology and Obstetrics.[2]

In this classification, Stage I cases are those with the growth limited to the ovaries. Stage II cases involve ovaries and pelvic extension. Stage III cases involve intra-abdominal disease. Stage IV implies metastasis outside the peritoneal cavity.

Table I records the distribution of the total cases by histologic type and clinical stage. The

TABLE I

OVARIAN CANCER—124 CASES

Cell Type	
Serous	56
Mucinous	17
Adenocarcinoma	18
Endometrioid	1
Other cell type or incomplete data	32
Clinical Stage (International Federation)	
Stage I	22
Stage II	23
Stage III	44
Stage IV	17
Incomplete data	18

32 cases labeled special cell type or incomplete data include granulosa-theca tumors, dysgerminomas, arrhenoblastomas, teratomas, anaplastic and unclassified cancers and referred cases not explored at this institution and not having slides or pathologic reports submitted. The bottom half of the table is the clinical staging. Of cases with adequate data for staging, 58 per cent were Stage III (abdominal spread) or Stage IV (spread beyond the peritoneal cavity), and thus, were totally unresectable at their first diagnosis. Many Stage II cases had parietal peritoneum of the pelvis involved and also were not completely resectable. Many in the incomplete data group were advanced disease also.

Of the 124 cases, 68 received systemic chemotherapy. The majority of these cases have been treated since 1960. Chlorambucil was the chemotherapeutic agent used in the vast majority of cases. Generally, an attempt was made to maintain an absolute lymphopenia below 1000 per mm.[3]

CLINICAL RESPONSE

Four of 68 (6 per cent) demonstrated clear objective response (50 per cent reduction in mass, 50 per cent reduction in effusions, or both) for periods of greater than six months. An additional 15 patients (22 per cent) manifested arrest of disease progress for varying periods. Thus, 19 or 28 per cent of the cases showed objective regression or failure of progression.

Severe toxicity was rare and limited largely to the hematopoetic system. Two instances of severe

exfoliative dermatitis were recorded. Platelet depression under 100,000 was noted 11 times and white blood cell depression under 1,000 four times. No sequelae of these depressions occurred.

While there appeared to be many instances of symptomatic improvement, arrest of progress in 22 per cent of cases and objective decrease in disease of 50 per cent for at least six months in 6 per cent, we were primarily interested in the influence of drug therapy on survival. There were 51 cases of the germinal epithelial tumors (serous and mucinous and unspecified adenocarcinomas and endometrioid carcinoma) receiving chemotherapy. The largest group was the Stage III group.

Figure 1 illustrates per cent survival of the Stage III cases by time interval. We made no effort to distinguish responders from non-responders. The graph sorts out these two groups without any interpretation. Recognizing that Stage III cases are those with abdominal spread, it seems noteworthy that no patient who did not receive chemotherapy survived past 35 months. Influence of radiation therapy was not considered. It was used infrequently in these Stage III cases, but in

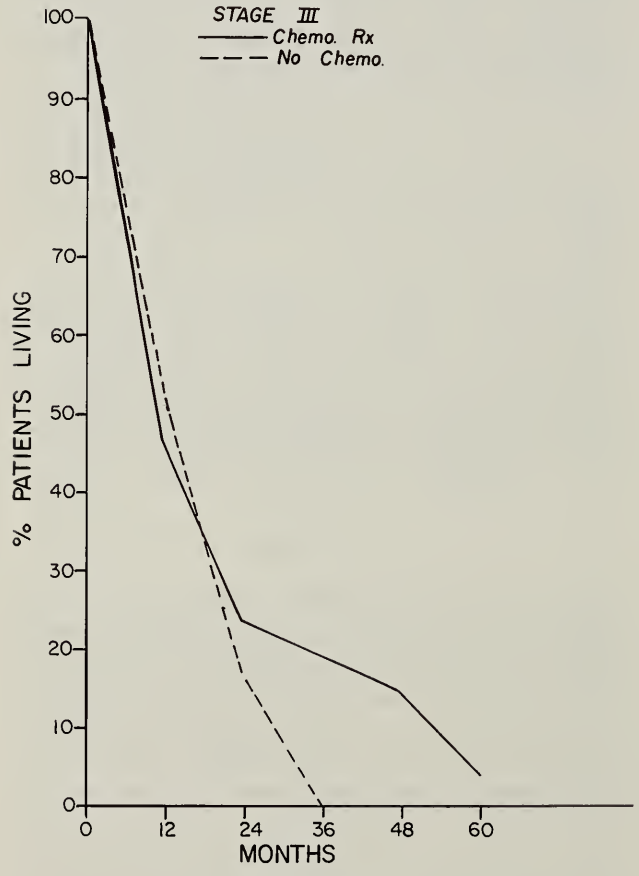


Figure 1

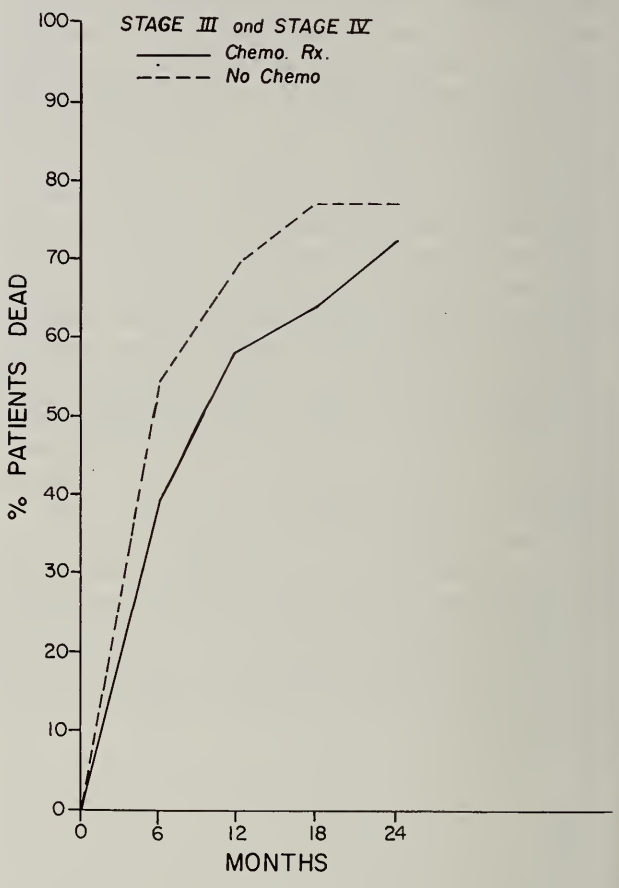


Figure 2

a comparable per cent of cases with chemotherapy and without chemotherapy. In this series four patients presently are on drug and completely without evidence of disease at periods of 13 to 53 months. One patient survived 51 months on drug. Not included in this graph is one Stage IV case now completely without evidence of disease after 35 months of drug. There were too few Stage IV cases to justify any comparison.

Figure 2 presents these data from the standpoint of per cent of deaths at six monthly intervals. All advanced cases were grouped (i.e., the Stage III and the Stage IV cases). There would appear to be a rather consistent four to six month survival advantage in the chemotherapy group.

SUMMARY AND CONCLUSIONS

1. There does appear to be a group of ovarian cancer patients who will be benefited by chemotherapy.

2. The per cent of responders varies with the criteria for response.

3. Responders do achieve some increased survival.

4. There appears to be a number of satisfactory drugs available.

5. The dosage schedule has not been clearly defined but we are now moving toward higher dose therapy.

6. The value of combined radiation and chemotherapy await further study.

7. We must pursue all aspects of available techniques permissible by medical and ethical consideration. Palliation is highly desirable but it is no substitute for cure. ★★★

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ART TREASURE

The man was irate over the estimate given him by a painter. "A hundred dollars for painting that garage! I wouldn't pay Michelangelo that much for painting it," he exclaimed angrily.

"Listen, friend," cautioned the painter, "if he paints it for a cent less, we'll picket your place!"

—JIMMY WARD *in the Jackson Daily News*

Radiologic Seminar LXXIX: Pneumatosis Cystoides Intestinalis

ELMER J. HARRIS, M.D.
Jackson, Mississippi

Pneumatosis cystoides intestinalis is defined as the intramural presence of gas within the intestinal tract. During infancy it has been associated with megacolon or other congenital obstruction of the intestinal tract. In such instances, the gas collects in small submucosal cysts. In adults the gas tends to accumulate in any layer of the bowel, particularly beneath the serosa. Some authors have expressed the theory that the condition is due to gas production by bacteria, but causal organisms have rarely been identified.

Others believe that it is the result of mechanical trauma with a break in the mucosa and dissection of air under the mucosa of the gastrointestinal tract. Some cases appear to be associated with duodenal or gastric ulcer. Pneumatosis of the large bowel has been reported to occur with pulmonary disease, severe cough and pneumomediastinum. Another etiological factor in colonic pneumatosis has been trauma to the rectosigmoid wall during proctoscopy.

The air pockets in the wall of the intestine take the form of discrete, localized or diffuse vesicles along the course of the bowel. These may vary in size from 1 to 2mm. up to larger ones, measuring 8 or 10 cm. in diameter. These cysts occur most frequently along the anterior mesenteric border of ileal loops and in the distal half of the colon but may involve any portion of the intestinal tract. They usually appear sessile but may be pedunculated, sausage-shaped or spherical. Sometimes the gas dissects its way into the peritoneal space and lodges subdiaphragmatically and may, therefore, be considered as one of the causes of spontaneous pneumoperitoneum. The gas may produce an invagination of the mucosal or muscular coats with a reduction in diameter of the lumen of the bowel causing partial or even complete obstruction. Volvulus may develop as another complication.

The radiographic appearance is rather typical (Figures 1 and 2). The barium column in the intestinal tract is surrounded to a greater or lesser degree by gas pockets which are readily recognized. In performing a barium enema examination, it is often impossible to fill out the lumen completely because of the pressure exerted by the tense gas cysts. The structures may be inconstant and variable in size and often shift their position daily. The condition may be discovered as an incidental finding on routine examination, and treatment is not generally effective unless underlying correctible cause is identified. ★★★

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Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Hospital.

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Figure 1. Barium enema showing air-containing cysts in the lower descending and upper sigmoid segments.



Figure 2. Mucosal relief study of this same area. Arrows indicate limits of involved bowel.

SUPERFAN

Every football coach would be happy to have a back who never misses a block, always makes eight yards per carry, completes every pass he throws and never fails to catch one thrown to him, who can punt an average of 60 yards, and can kick field goals from the 40 yard line.

So far, there hasn't been any way discovered to get him to lay aside his bag of peanuts and Coke and come down out of the stands to the bench.

Profile of Attainment–Measure of Need, Part V

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

In the fifth and final part of the series on postgraduate medical education in Mississippi, a proposal to establish a formal institute as an adjunct to the University Medical Center is examined. The potential of the institute approach is evaluated, and its probable impact on physicians with varying amounts of postgraduate training is assessed.

A point-by-point summary of the findings and conclusions in the initial study comprises the summary for this five-part series.

In 1967, the Council on Medical Education of the Mississippi State Medical Association made this observation:

> "The state of Mississippi has been a generous participant in the national lag in effective postgraduate medical education. With medical knowledge and advances accumulating at an ever-increasing rate, it is becoming increasingly difficult to defend the usual practice of four years medical school followed by 30 to 40 years of active medical practice unaccompanied by dedicated effort toward the formal acquisition of modern medical knowledge.
>
> "While some effort has been expended to provide opportunities for continuing education, in general the program has been narrow, limited, fragmentary, and for the most part, without continuity. Many indications suggest that physicians and the general public are now in the proper frame of mind to revitalize the entire approach to postgraduate medical education. The problem is too broad and too complex to be effectively met by any one segment of the health team; successful resolution will be realized only after a community-wide approach is formulated and executed."

In its subsequent studies and discussions, the council became intrigued with the idea of a Mississippi Postgraduate Medical Institute as a unified approach to the need for continuing training. It seemed logical for the Institute to be an adjunct to the University Medical Center, because this arm of the University of Mississippi has as its primary mission the teaching of medicine at undergraduate and graduate levels.

The medical center possesses faculty resources, research facilities and capabilities, cataloguing and retrieval capabilities, and clinical demonstration ability. These are, of course, the primary minimum components of a university teaching center, and they are logically geared to undergraduate and full-time graduate medical education, as in the cases of medical students, interns, residents, fellows, and doctoral candidates in the allied medical and health sciences. What is vital in continuing postgraduate education for the practicing clinician in the intelligent and effective application of these resources in his behalf and according to his desires.

Such resources must be specially organized and communicated at a level adjusted to the needs and learning-time-available of the prac-

Chairman, Council on Medical Education and member, Board of Trustees, Mississippi State Medical Association.

Adapted from the study report approved by the House of Delegates, 100th Annual Session, May 13-16, 1968.

titioner. As tentatively conceived and discussed, the Institute would be a permanent facility adjacent and adjunctive to the University Medical Center. It would have its own staff and administrative organization which would specialize in the unique functions of the Institute.

Since total medical involvement is indicated in the success of the Institute and its programs of service in lifetime learning, participation in the formulating and organization of its programs calls for partners. The Mississippi State Medical Association and the State Board of Health should be partners in planning, curriculum development, and program direction. It is especially urgent that the voice of the practicing physician and his state medical association be fully represented in this endeavor, as should be the voice of public health in the state.

Thus, the University Medical Center would be responsible for dispensing and supplying the product which is education for physicians at the postgraduate level. But because the physician himself is the consumer, he should be active in expressing his wishes as to what sort of product he wants supplied.

PUBLIC HEALTH DATA

The State Board of Health possesses a vast wealth of data on the incidence and status of disease processes, and many problems which can be effectively attacked and alleviated by postgraduate programs have been just and longstanding concerns of the State Board of Health.

Such a well-staffed and suitably equipped facility would be able to offer a variety of postgraduate educational services. Preliminary concepts in this connection are:

—*For recent medical graduates:* This program would be designed to attract the recent graduate who is in general practice, and if so desired, each participant would be individually assigned a faculty adviser who would assist him in developing a program of study over a five year period. The young practitioner might even spend up to three weeks annually in residence at the Institute, say one week every three months during the academic year. He would remain in communication with the Institute, and his faculty adviser, a member of the Institute staff, would assure that he is furnished with timely bibliographies of selected materials, tapes, films, and reprints of subject areas under study. A typical postgraduate program might include medicine in the first year, pediatrics during the second, obstetrics and gynecology during the third, psychiatry in the fourth, and an elective field during the fifth and final year. The level of study should be such as to offer appropriate academic credit and evidence of achievement upon successful completion of the program.

PHYSICIAN BENEFITS

—*For older physicians:* For those physicians who have been in practice for a number of years, individual programs of postgraduate study would be designed and especially adapted to meet the needs and requirements of those with the seasoning of wide clinical experience. It would be possible to tailor the program along the lines of those offered the younger physicians in an effort to fit individual need and assure personal services through a faculty adviser. As with the other program, suitable credit and recognition should be extended by the Institute to those older physicians who successfully complete the work.

—*For certified physicians:* For physicians certified by their respective American boards, the Institute could offer week-long courses characterized by intensive consideration of sophisticated and advanced subjects presented at advanced levels of study. Participants would actually manage patient care in joint effort with instructors and would also gain experience in appropriate procedures carried out in experimental laboratories. Of necessity, these groups of certified physicians would be small at any one time, and the work would be intensive and demanding.

—*Short didactic courses:* Twice monthly, the Institute would sponsor short, intensive didactic courses similar to those now being offered by the University Medical Center through its Committee on Postgraduate Medical Education. Sufficient clinical orientation would be structured into such short courses to make them attractive, and it is contemplated that a breadth of interest and wide variety of offerings would be continued so as to serve all spheres of professional interest.

POSTGRADUATE CIRCUITS

—*Circuit courses:* This aspect of the program would be an extension of the Institute concept into the physician's home community and to his community hospital, where desired. It would also represent an expansion of the existing UMC circuit course program. Use is now being made of community hospitals which are logically the focus of postgraduate medical instruction at the professional community level, but instruction through this training vehicle is largely limited to

didactic lectures. The Institute would seek improved methods of instruction with increased participation by the faculty, including clinical demonstrations, ward rounds, and study in depth of particularly pertinent cases. In brief, the circuit course program would be much more clinically oriented.

Implicit in any effective program of continuing postgraduate medical education is the maintenance of current clinical data which has a ready relationship to medical practice. Maintenance of morbidity and mortality data in forms for continual computer processing would assist in discharging this function. Of course, the Institute would not duplicate similar endeavors, such as the keeping of vital statistics by the State Board of Health.

Field force visits to hospitals could study disease incidence, procedures being employed, and current physician opinion and experience with therapeutic agents. Such activities could particularly assist in study projects already established, i.e. maternal and perinatal mortality and incidence of cancer. These additional data could greatly assist committees and other bodies compiling and evaluating these data, and this activity should also be useful in building data banks with direct application to patient care and continuing postgraduate medical education.

Finally, the Institute should and could contribute to research in continuing postgraduate medical education through evaluation of teaching and communications techniques, measurement of results, and through continual study of professional attainment by maintenance of a profile of postgraduate education achievement.

SUMMARY AND CONCLUSIONS

This study report has been limited to findings and conclusions with appropriate presentation of data arrays, narrative discussion, and documentation. The council has made recommendations to the Board of Trustees and House of Delegates of the Mississippi State Medical Association, but we feel that inclusion of these recommendations here would be inappropriate in a report of serious study and research.

A unique measure of professional attainment among Mississippi physicians was undertaken by studying postgraduate medical education received among 1,108 in the nonsurgical disciplines and 412 in the surgical disciplines.

Extent of Formal Postgraduate Training. Of 1,108 Mississippi physicians in the nonsurgical disciplines, 464 have received only one year of internship in formal postgraduate training. Excluding general practitioners who are currently forming a program leading to certification, only 50 in this group received only the year of internship with the remainder having had varying periods of training, largely conforming with requirements of their respective specialties. Of the nonsurgical specialists studied, 45.98 per cent have been certified by their respective American boards. Four out of five nonsurgical specialty disciplines show a mean formal postgraduate training time in residencies of more than three years.

WELL-TRAINED SURGEONS

Only 32 of the 412 in the surgical disciplines received only the one year of internship as the extent of formal postgraduate training, and five of nine disciplines show median training of four years or more. Of those studied in the surgical disciplines, 45.14 per cent are diplomates of their respective American boards.

Opportunity for Continuing Education Benefits. It is concluded that the profession in Mississippi, although differing widely in many instances as to formal postgraduate training achievement, could and would benefit from improved programs in continuing postgraduate medical education. The composite profiles of professional attainment show that these programs are more immediately applicable to some than others and that the opportunity to make beneficial use of a variety of programs, geared to various levels of achievement, does exist.

A survey of the membership of the Mississippi State Medical Association was made to determine their personal opinions as to needs and desires in programs of continuing postgraduate medical education. An excellent, valid response was received.

Value of Postgraduate Medical Education. Mississippi physicians believe that a program of postgraduate medical education, tailored to their own needs and desires would be desirable and helpful, and fully half of the profession think it extremely desirable.

Assessment of Existing Programs. Existing programs of postgraduate medical education available to Mississippi physicians are thought to be helpful by a majority, but a more formalized approach and organization of the programs is believed necessary. A third of the physicians classify existing programs as inadequate, while a very few support the *status quo.*

Postgraduate Medical Institute. A Mississippi Postgraduate Medical Institute, organized and built as an adjunct to the University Medical Center would have the support of 19 out of 20 Mississippi physicians who believe that it would be useful and who would participate in its programs.

Instructional Preferences. An overwhelming majority of Mississippi physicians prefer clinically oriented instruction in any program of postgraduate medical education, including concurrent experience in patient management under qualified instructors and wet clinics.

Organization of Postgraduate Medical Education. Any formal program of continuing education for Mississippi physicians should be organized in a combination of an on-campus institute, intensified home area circuit courses, and offer participating physicians the personal services of a faculty adviser who would guide in the development of a personalized program tailored to meet the individual's needs and desires.

Electronic Communications Media. At some future time when a program of postgraduate medical education has been developed in Mississippi on a formal and organized basis, a closed circuit television system with receivers in hospitals and other facilities convenient to physicians would be a valuable adjunct to the program. An educational radio network is not an acceptable communications medium for this program.

Postgraduate Program Value by Disciplines. Mississippi physicians in nonsurgical specialties appear to place a higher value on postgraduate medical education programs than those in the surgical specialties, but the degree of difference is not in an extreme. The "overlapping specialties," i.e., general practice, internal medicine, and pediatrics, are far more eager to establish formal programs than are the "nonoverlapping" specialties. There is, however, no significant lack of interest in formal programs of continuing education among all practitioners in the state.

PG PROGRAM ASSESSMENT

Existing Programs by Disciplines. There is almost total agreement among surgical and nonsurgical specialties in Mississippi that existing postgraduate medical education programs are not completely adequate as constituted. The degree of inadequacy varies among the nonsurgical fields. Most physicians believe present programs helpful but urge a more organized and formalized approach.

The Proposed Institute by Disciplines. The numerically larger surgical and nonsurgical specialties support the proposed postgraduate institute by substantial majorities. In all but four specialties, at least nine out of 10 expressed support and indicated in varying degrees that they would participate in its programs.

Instructional Method Preferred by Disciplines. Each specialty gives an overwhelming endorsement to clinically oriented instruction in any program of postgraduate medical education.

PROGRAM ORGANIZATION

Postgraduate Organization by Disciplines. Specialists, as individual groups, are consistent in believing that any postgraduate medical education program should be organized as a combination of an on-campus institute, clinically oriented, with home area circuit courses, and the personal services of a faculty adviser in personally designed programs.

Electronic Media by Disciplines. Most specialists find merit in some degree in use of closed circuit television with receivers in hospitals and other convenient locations, but they believe in overwhelming numbers that FM radio is neither desirable nor useful as a program communications medium.

A study of existing formal postgraduate programs in Mississippi as to internship and residencies and of continuing postgraduate medical education programs was made.

Postgraduate Programs in Mississippi. Postgraduate programs in Mississippi are presently minimal with only one source offering continuing education. Regularly scheduled medical meetings are varied in attendance characteristics and educational offerings. Only slightly more than 1 per cent of continuing education programs for physicians nationally are available in Mississippi. The four immediately adjacent states have two to 15 sources each for these programs in contrast to Mississippi's one source.

The Challenge of Mississippi's Future. Mississippi ranks 19th nationally in first year medical students per 100,000 bachelor degrees awarded in 1966 and ranks 21st nationally in entering first year medical students per 100,000 population. The challenge of meeting the postgraduate education needs of these future physicians is clear.

Formal Postgraduate Opportunities. Mississippi lags significantly behind the four immediately adjacent states in formal postgraduate opportunity in internships and residency programs. It is clear that Mississippi cannot meet its own need for

training in the specialties. Mississippi also lags behind comparably populated states in these respects.

UMC Postgraduate Programs. The two major continuing medical education programs in Mississippi are UMC seminars and circuit courses. In studies of these programs during 1966 and 1967, it is observed that attendance upon the seminars is increasing, but there is a notable decrease in circuit course participation.

Three major studies relating in part or whole to continuing education for physicians in the United States wer ereviewed.

Coggeshall and Millis Reports. Although conducted without similar objectives, both the Coggeshall and Millis reports stress the urgent need for improving both formal postgraduate and continuing education for physicians. University centers have a primary challenge and opportunity—although not a total responsibility—in these areas.

Regional Medical Programs. Fifty-one regions in the United States have been defined in the Regional Medical Programs, and most are placing significant emphasis on continuing education for practicing physicians. Among members of the mandatory advisory bodies in these programs, practicing physicians constitute the largest single group.

AMA Accreditation Program. After 12 years in development, a formal accreditation system for continuing education programs for physicians has been instituted by the American Medical Association. It is imperative that such programs organized in Mississippi conform fully with these new and important quality standards.

The Council on Medical Education of the state medical association has suggested the idea of a Mississippi Postgraduate Medical Institute as a unified approach to meeting the need for continuing education.

Nature of the Institute. It seems logical for the Institute to be organized and constructed and adjunct to the University Medical Center, to make use of the center's faculty resources, and to offer the services of necessary staff. Since it is urgent that the voice of the practicing physician be heard in this endeavor, it is also logical for the Mississippi State Medical Association to have representation in planning, curriculum development, and program direction. Because of its interests in and involvement with the health of all citizens, the State Board of Health should also be a partner in the Institute.

Institute Approach. The Institute should serve the profession in a variety of ways with programs tailored to the personal needs of recent medical graduates, older physicians, and physicians who are certified by their respective American boards. All Institute work should lead to suitable academic credit and evidence of achievement upon completion. It should also be responsible for seminars and intensified home area circuit courses. There are other roles for the Institute in scientific studies and education research. ★★★

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This study was assisted in part by the Regional Medical Program of the University Medical Center, Jackson.

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Clinicopathological Conference XCI

Conducted by the Department of Pathology
Mississippi Baptist Hospital
Jackson, Mississippi

A 74-YEAR-OLD, white man had been previously admitted to another hospital on November 20, 1964 because of dizziness, loss of balance, numbness of right leg, and loss of control of right arm which was diagnosed as due to thrombosis of the posterior inferior cerebellar artery. On that admission the WBC was 9,900, with 7 monocytes, 16 lymphocytes, 3 eosinophils, 71 segmenters, and 3 basophils. The hemoglobin was 17 gm. per cent and SGOT 46 units. Urea nitrogen was 18 mg. per cent, uric acid 5.5 mg. per cent, and alkaline phosphatase 2 BU. X-ray of the chest revealed both lungs to be within normal limits. He was discharged much improved 12 days after admission.

He was admitted to the Baptist Hospital on April 13, 1967 because of weakness and constipation. During the past two months the patient had become progressively weak, to the point that he found it difficult to get out of bed. It was stated that since he had a right-sided stroke in 1964 he had not fully regained use of himself and that he had been somewhat weak and slow in all his activities and that his speech had been slurred. However, up until recently he had been able to walk two miles a day without any trouble.

During the past four or five months he had had progressive constipation despite a large intake of water, prunes, prune juice, and laxatives. He had had some hemorrhoidal bleeding but no blood mixed with the stools. He had had no fever, chills or night-sweats, but he had some lower abdominal discomfort and borborygmus associated with flatulence. He had been proctoscoped one month prior to admission, and no abnormalities were found. Colon x-ray at that time revealed sigmoidal diverticulitis, but otherwise it was unremarkable. The patient continued to be constipated, and his appetite was declining.

Physical examination revealed a well-developed, fairly well-nourished white male who appeared chronically ill but was in no acute distress. The blood pressure was 110/70; pulse, temperature and respiration were normal. Lungs, heart, and abdomen were negative. The impression of the consultant neurologist was that the patient had some cerebral arteriosclerosis but that most of the patient's difficulties were on a systemic illness basis.

The patient in the November CPC is a 74-year-old white man who had been diagnosed as having thrombosis of the posterior inferior cerebella artery on a hospital admission three years earlier. His presenting symptoms on this admission were weakness and constipation. Discussers are Drs. Thomas E. Stevens, Robert P. Henderson, and Louis Schiesari.

Laboratory data on admission showed hemoglobin 11 gm. per cent; WBC 6,700; lymphocytes 39, eosinophils 2, segmenters 58, band 1; 4 nucleated RBC/100 WBC; urine negative; creatinine 1.2 mg. per cent; glucose 80 mg. per cent; potassium 4.5 mEq.; sodium 128 mEq.; urea nitrogen 22 mg. per cent; occult blood in feces 1+; acid phosphatase 0.5 BU; total protein 6.20, albumin 3.7, globulin 2.5; SGOT 93 units; alkaline phosphatase 9.5 units; BSP 8 per cent retention; calcium 10 mg. per cent; bilirubin, direct .35, total .65 mg. per cent; spinal fluid total protein 97 mg. per cent; spinal fluid cell count 2 lymphocytes per cubic millimeter.

Sputum cultures yielded coagulase positive *Staphylococcus* and were negative for fungi and

acid-fast organisms. X-ray of chest showed parenchymal changes suggestive of fibrosis. Metastatic neoplasm entered also into consideration, but inflammatory origin seemed more likely. On the second day of admission it was stated that the neurological changes were somewhat more apparent. The patient kept the right eye closed most of the time and showed decreased strength in the right arm. He remained afebrile or showed only occasional slight temperature elevation to 100°. He became progressively weaker and less responsive. An operation was performed on the sixth day of admission.

Dr. Thomas E. Stevens: "Going over this, I think this man had what was felt to have been an incomplete lateral medullary syndrome due to posterior inferior cerebellar artery occlusion. There are some inconsistencies in this. The fact that sensory change was on the same side as the cerebellar signs would not fit this picture. Perhaps this could have been an erroneous recording. It would be of help to know if a spinal puncture was done at that time and if the cerebrospinal protein was elevated, but we don't have that information. At that time it should be noted that he recovered rapidly; he was not anemic; his alkaline phosphatase, chest x-ray and SGOT all were done and all were within normal limits. On readmission he was found to have an increase in the deep tendon reflexes on the right; he had slowed, fine movements on the right; but apparently no localized weakness was demonstrated by neurological exam. He later developed a ptosis of the right eye and demonstrable decrease in the strength of the right arm. He was reported to have slurred speech and had had progressively more difficulty with constipation in the four to five months before admission.

LABORATORY FINDINGS

"The significant studies recorded, I think, include a spinal fluid protein of 97 mg. per cent with a normal cell count; the hemoglobin of 11 gm. per cent whereas it had been 17 gm. per cent before; the 4 normoblasts per 100 white blood cells in the peripheral blood at the time of the second admission; the low serum sodium 128 mEq./L.; the SGOT 93 units; alkaline phosphatase 9.5 Bodansky units; BSP retention of 8 per cent; a chest x-ray which showed parenchymal changes suggesting fibrosis; and, finally, a sputum culture showing coagulase positive *Staph. aureus*. I would like just to exclude the neurological symptoms and signs from discussion just a minute and go on with the other findings.

"The alkaline phosphatase increase coupled with the SGOT and BSP increase, of course, direct our attention to the liver. The alkaline phosphatase could possibly be coming from the skeletal system which certainly seems to be involved in the process here. However, we know that the liver origin of alkaline phosphatase is up in the elderly whereas bone-derived alkaline phosphatase is more prevalent in children. There are tests now available with which we can selectively analyze the phosphatases of different tissue origins.

LIVER CELL DESTRUCTION

"I think, with the SGOT and other findings, we have good evidence of liver cell destruction with involvement of the canaliculi as reflected in the increased alkaline phosphatase and a disturbance of excretory function without any retention of the bilirubin. I think the anemia is striking, primarily the difference in the level of the hemoglobin. This, coupled with the increased peripheral blood normoblast count, would cause me to surmise that there was either a small amount of bone marrow operating at an increased rate or some site of extramedullary hemopoiesis.

"The findings on chest x-ray coupled with the lowered serum sodium certainly raise the possibility of the syndrome of inappropriate antidiuretic hormone excretion of pulmonary etiology or of tumor elsewhere with metastases to the lung. And, finally, the central nervous system protein increase without an increase in cells suggests a non-infectious etiology of the CNS changes but certainly could be due to a solitary tuberculoma without meningeal involvement or on a long shot —multiple sclerosis. I wonder if it would be a good idea now to look at the chest films? Dr. Henderson, would you comment on the films?"

Dr. Robert P. Henderson: "There is an extensive infiltration throughout both lung fields, and it has a fine nodular component to it (Figure 1). On the projected film it is difficult to appreciate these nodular lesions. Interspersed with the infiltration are a few ill-defined cystic areas which could conceivably represent small areas of cavitation but do not have a well-defined wall. This infiltration is not a fibrosis and should not be considered as a chronic process. The differential should include both granulomatous processes and metastatic malignancies."

Dr. Stevens: "Let me ask just one thing. Would the picture we see here be compatible with what we call a lymphangietic type of infiltrate?"

Dr. Henderson: "Yes, it could be, but again because of the peripheral nodularity and sparing of the central lung area with no evidence of hilar involvement the findings would favor an embolic spread and a lymphatic type of infiltration."

MALIGNANCY PROBABLE

Dr. Stevens: "Putting the picture together, at least as I see it, I would exclude multiple sclerosis on the basis of this man's age and his multisystem involvement. I think TB could account for the liver, lung and central nervous system changes, but with the absence of fever and an increase in cerebral spinal fluid cells, this certainly would be a long shot. Certainly, cirrhosis of the liver should be mentioned and could well account for the liver function studies, but the abnormalities would explain none of the other findings. I believe that this man had a malignancy which was metastatic to the liver as reflected in liver function abnormalities, to the bone as reflected in the bone marrow or the nucleated red cells in the peripheral blood, and probably to the lung in a lymphangietic fashion.

"I think he most probably had the syndrome of inappropriate antidiuretic hormone secretion



Figure 1

that is found with carcinoma of the lung, carcinoma of the pancreas, infectious diseases of the lung, and a number of other things; and I would



Figure 2

put all my eggs in one basket and say that the tumor was probably primary in the pancreas. I think the central nervous system findings represent probably metastases. I think a combination of things should be considered. I think the inanition that this man had and has systemic disease could have exacerbated or compromised vascular flow from the previous stroke and caused him to have these symptoms, but of course this would not explain the elevated protein in the spinal fluid. As to what operation he had—I don't know. I would include possibly a biopsy of the liver and an exploratory laparotomy."

SURGERY PERFORMED

Dr. Louis Schiesari: "The operation consisted of a biopsy of a scalene lymph node. On this lymph node which measured less than 1 cm. in diameter and grossly was not remarkable, a frozen section diagnosis was rendered. A few hours later the patient expired. At autopsy the pleura, peritoneum, lungs, spleen, liver, kidneys, and GI tract from esophagus to the rectum were riddled with innumerable grayish-white, smooth nodules

varying from a few millimeters to 2-3 cm. in diameter. The lymph nodes were not enlarged, and, in fact, I had difficulty finding a few nodes for the routine microscopic examination. The meninges were covered with a thick coat of creamy grayish-white exudate.

"The first slide (Figure 2) is a picture of lung with the pleura showing innumerable closely spaced, elevated nodules. All the organs mentioned above presented more or less the same gross appearance. The second slide is a closer view of the same lung. The next slide shows the gastric mucosa transformed into huge brain-like convolutions formed by the enormously enlarged rugae. The next slide (Figure 3) shows the bone marrow diffusely infiltrated by monotonous round cells unquestionably of the lymphoid type. The next slide (Figure 4) shows the mucosa and wall of the small intestine almost completely obliterated by the same type of cells.

LYMPH NODE SECTION

"The next slide (Figure 5) is the permanent section of the lymph node which was submitted for frozen section. As you see, one cannot make with certainty a diagnosis of malignant lymphoma looking at this section since this has much the appearance of a sinus hyperplasia with a germinal center still visible in the lymphocytic cord. Diagnosis on this node is impossible on a frozen section, but when we touch the fresh cut surface of this node with a slide and then we stain it for three minutes with Giemsa's stain, then we have an entirely different picture and the diagnosis becomes quite obvious as you can see from the next slide (Figure 6). It was on the basis of this slide that the correct diagnosis of lymphosarcoma was rendered on the frozen section specimen.

HALLMARK OF MALIGNANCY

"What to call these cells is probably a matter of opinion. The presence of vacuoles in the cytoplasm is considered a hallmark of malignancy for these type of cells. You can call them blasts if you want since this is quite a loose term, every hematologist having his personal blast. I prefer to call them lymphosarcoma cells since the blast is a cell identified with the immature cell found in the peripheral blood. In this case in spite of the massive lymphomatous infiltration throughout the body these cells were not found in the peripheral blood. We, then, can conceive of these cells as having been affected by malignancy before reaching the blast phase; namely, in their way to develop from the reticulum cells to the blast cell.

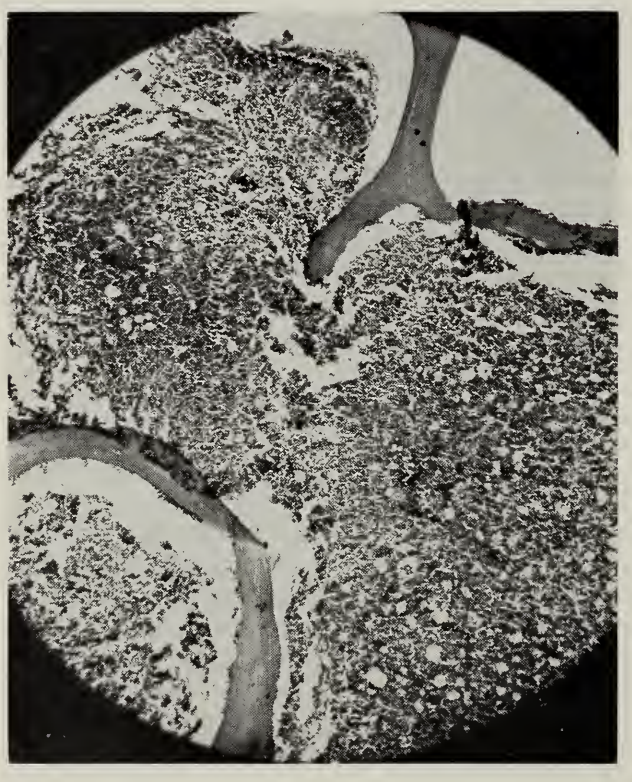


Figure 3

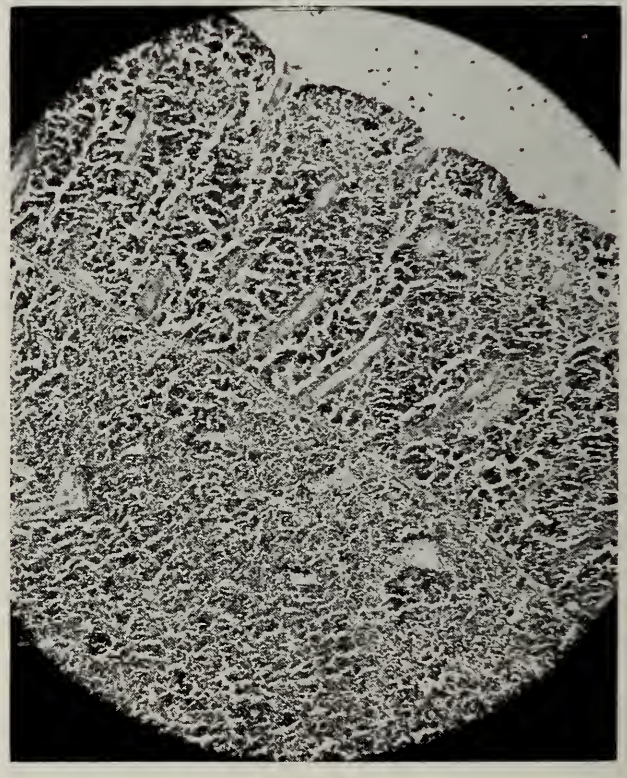


Figure 4

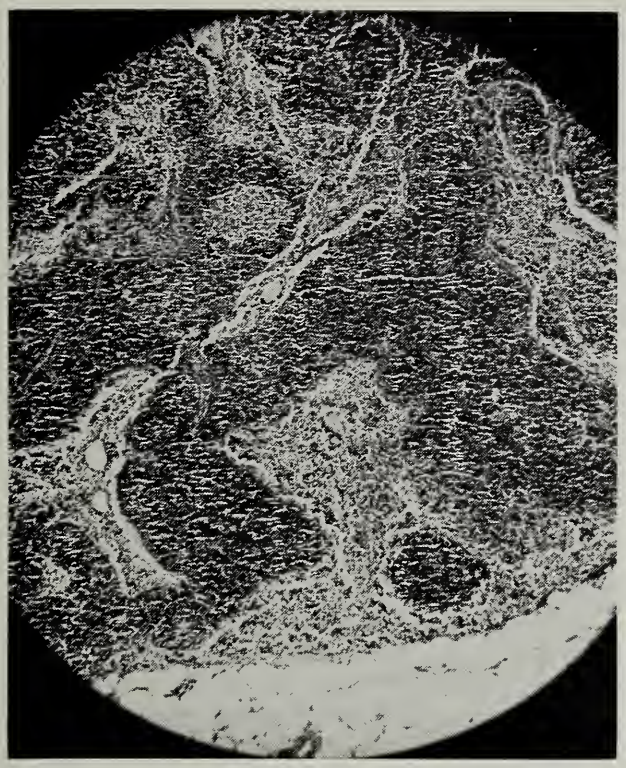


Figure 5

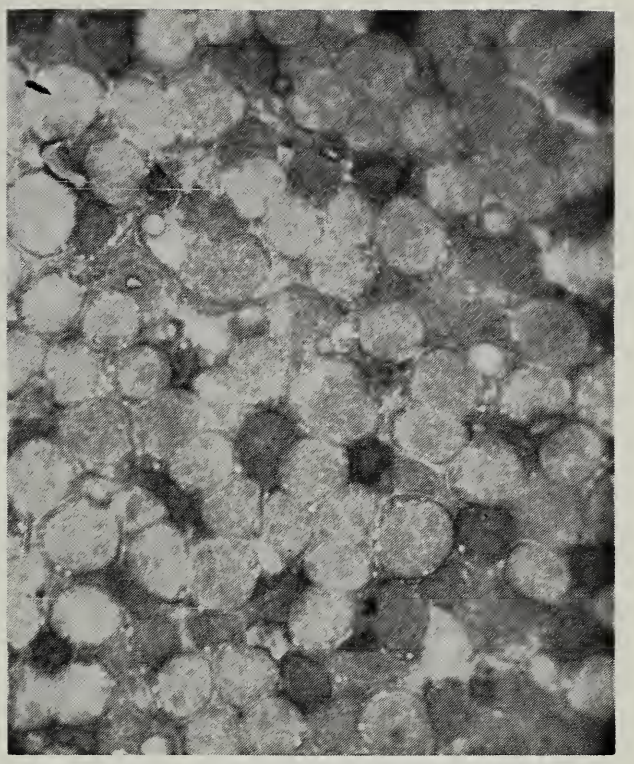


Figure 6

Our final pathological diagnosis, therefore, is as follows:

Lymphosarcoma (malignant lymphoma, lymphocytic type, poorly differentiated) involving:

a. Bone marrow
b. Lungs
c. Gastrointestinal tract
d. Kidneys
e. Liver
f. Meninges
g. Adrenals
h. Thyroid
i. Spleen
j. Pleura
k. Peritoneum
l. Lymph nodes.

"I put intentionally the lumph nodes in the last place since grossly they were the least affected by the lymphomatous involvement, and on the basis of this finding perhaps the best term for this type of condition would be diffuse malignant lymphoreticulosis." ★★★

1190 North State St.

OF MICE AND MEN

The experimental mouse was returned from the laboratory to his cage. Running up to a fellow mouse, he said, "I have finally got Dr. Jones conditioned."

"How is that?" asked the second mouse.

"Easy," said the first. "I simply run through the maze and he gives me the food."

Intramuscular Perphenazine For the Treatment of Disturbed Behavior

ROBERT M. RITTER, M.D.; W. L. JAQUITH, M.D.,
HENRY RAY NAIL, M.D., and JOHN JAMES HEAD, M.D.
Whitfield, Mississippi

In a previous article[1] the use of oral perphenazine (Trilafon) in the treatment of outpatients was reported. Perphenazine has been used at Mississippi State Hospital since 1957, and the clinical experience with intramuscular perphenazine led to the conclusion that its effectiveness, ease of administration, and low incidence of side effects made it the drug of choice in the treatment of disturbed behavior in a large mental hospital. The authors' clinical experiences with this use of perphenazine is the subject of this article.

Disturbed behavior is here defined as that behavior in either an acutely or chronically ill patient which is unacceptable for one or more of the following reasons: (1) prolonged emotional unrest which would exhaust the patient or result in his injury or illness; (2) threatening or overt aggressive behavior; (3) loud and unruly behavior which disrupts the ward and disturbs other patients.

At Mississippi State Hospital an officer of the day system is used on nights and weekends. A "log book" kept by the physician on duty details his activities. All admissions, illnesses, injuries, and medications administered are recorded. This log was reviewed for the period April 1, 1966, to April 1, 1967, tabulating the frequency with which perphenazine was administered intramuscularly because of disturbed behavior. Any unfavorable reactions were recorded as was failure of perphenazine to accomplish the desired result as indicated by the necessity to repeat the injection or administer other therapy. Generally, 2 cc. of perphenazine was given intramuscularly for disturbed behavior, although the dosage ranged from 1 cc. to 2 cc.

During this 12-month period, a total of 2,006 injections were given: 1,035 such injections were given by nurses who were carrying out previously written p.r.n. orders by ward physicians; 971 injections were given by the officers of the day who had been called to see patients experiencing severely disturbed behavior.

The records of 2,006 patients at the Mississippi State Hospital who had been given nighttime injections of perphenazine for disturbed behavior were reviewed. This review supported the authors' clinical impression that intramuscular perphenazine is a highly effective agent and the drug of choice in controlling disturbed behavior with few mild-moderate side effects.

First, the self-abusive patient was usually noted to relax and frequently to lie down and go to sleep within 30 minutes after the injection. The threatening, aggressive patient was often found to be more manageable in the same amount of time. The loud, unruly patient was usually profoundly affected within a hour. However, the patient falling into the last group did require a repeat injection more frequently than those who fell into the first two groups.

During the 12-month period no patient required electroshock treatment during the night hours, and no other phenothiazine or sedative was used after the Trilafon injection. It should be noted, however, that the patients involved were not infrequently being given other phenothiazines in their treatment regimens.

Side effects from the single injection of per-

From the Mississippi State Hospital where Dr. Ritter is director of research, Dr. Jaquith is director, Dr. Nail is director of medical-surgical services and Dr. Head is clinical director.

phenazine were rare. Dizziness and mild hypotension were encountered on rare occasions. Symptoms referable to extrapyramidal reactions were usually mild and were encountered in less than 1 per cent of the patients studied. We feel that this small percentage of extrapyramidal reactions to the single dose of perphenazine is worthy of note since extrapyramidal reactions to the maintenance use of perphenazine, although easily controlled with Cogentin, are significantly higher.

One patient developed urinary retention, but it cannot be stated with certainty that this directly resulted from the use of intramuscular perphenazine since the patient was on other medications as well. No reactions were encountered at the sites of injections, and we are convinced that intramuscular perphenazine may be given safely by nurses on p.r.n. orders.

In summary, the records of 2,006 patients at the Mississippi State Hospital who had been given nighttime injections of perphenazine for disturbed behavior were reviewed. The review of these records supported the authors' clinical impression that intramuscular perphenazine is a highly effective agent, and the drug of choice, in controlling disturbed behavior with few mild-moderate side effects. One patient developed acute urinary retention which may or may not have been associated with the intramuscular use of perphenazine.

★★★

Mississippi State Hospital (39193)

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PLATOON SYSTEM

"Coach," said a fan outside the locker room of the visiting team, "we understand that you have a chaplain who counsels and prays with your squad. I'd like to meet him."

"Of course," replied the coach, "but which one would you like to meet: the offensive or defensive chaplain?"



The President Speaking

'The Need Will Be Met'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

THE MIAMI BEACH clinical convention of AMA will be preceded by a meeting of key importance to practicing physicians. On Nov. 30, a conference on community health planning will be conducted. and it may well be a preview of things to come in medicine.

There is no argument against sound planning for best utilization of our medical resources. This is to say that we ideally ought to have every hospital bed which we need and not a single bed which we do not need. The same is true of professional manpower, of allied professional personnel, and of all health care resources. Physicians are always glad to receive support in their efforts to give their patients the best possible care.

But some aspects of community health planning appear frightful in the context of what is being proposed. Among such proposals are various types of "free clinics," expansion of medical facilities for convenience purposes, closed panel (prepaid group) practice organization, and frequently, a complete alteration in the private care delivery system.

New and heavy emphasis is being placed on consumer conveniences in securing medical care. One such proposal is clinic operation during evening hours, thereby eliminating the "inconvenience" of seeking care during what we call usual office hours. Still further emphasis is being placed on lay referral services, sometimes under government programs of care.

We in private practice should seriously consider the impact of such suggestions and what we, as individual physicians, can do to make such moves unnecessary. For example, where patients are so situated that seeing a physician in evening hours is necessary (even in the absence of an urgent circumstance or emergency which are already provided for), we might think of maintaining hours one evening a week on a staggered basis, just as we arrange for days or afternoons off. Where this is spread among all physicians in a community, there could be little justification for "free evening clinics."

This is only a single example, but private medicine has full capabilities of meeting medical need, and it will continue to do so effectively. ★★★

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EDITORIALS

Hospitals in 1969: Fewer Institutions, More Beds, New Capabilities

I

THE CHANGING COUNTENANCE of American medicine more often than not shows up in the hospital. Most hospitals quickly adapt to changing roles in medical care capability, largely brought about by forward thrusts in the science of medicine. Hospitals also respond to public demand for services, and this demand is proportionately related to purchasing power.

The board base of voluntary health and insurance and prepayment plans has, in effect, been expanded with the advent of Medicare, Title XIX, and a host of federally-assisted programs under which medical care is purchased. Nobody need be reminded of the pressures which can be generated in a bull market with short sales against future deliveries. The enactment and development of more and more care programs make for exactly such situations, and the hospitals feel the squeeze.

The manpower problem, another issue of staggering magnitude, cannot but help aggravate the demands upon physical facilities of the nation's hospitals. The population continues to increase, especially in the older age brackets. Combine this purely demographic factor with the economic aspect of growing purchasing power, and the reaction can be explosive. But in the face of all of this, the nation is doing a remarkably able job of medical facilities construction and modernization. The profession measures up, too, and the future is brighter than the past was dim.

II

The United States Public Health Service has recently released a new report of its studies on Hill-Burton state plan data. Of almost equal importance to the construction part of the program is the continuing and orderly appraisal of medical facilities.

Each state plan must include an inventory of all nonfederal inpatient and outpatient facilities exclusive of mental hospitals, institutions furnishing domiciliary care, and institutions considered as not providing a community service. With the enactment of the Community Mental Health Centers Act in 1965, the Hill-Burton program was relieved of inventorying mental care facilities.

The recent data reflect initiation of new procedures by the states. These include evaluation of hospital physical plants to determine the need for modernization, a uniform method of determining bed capacities based on space requirements, and a method of estimating bed need based on utilization experience.

Until 1964, the only federal criterion for "conforming" facilities and beds, as opposed to "non-

conforming," was whether a public hazard existed or not. The states made their own evaluations, determining what was and was not suited for proper patient care. Now, federal requirements include evaluation with reference to fire resistivity, mechanical and electrical construction, exits, fire alarm systems, interior finishes, and vertical shafts.

Also included are design and structural factors relating to patient care in room sizes and corridor widths and a number of requirements on ventilation, space dedication, and equipment.

Bed capacity is reckoned on space with minimums of 100 square feet for a private room, 80 square feet per bed in multibed rooms, and 40 square feet per bassinet.

Bed need is no longer calculated on so many beds per population unit alone. The complex formula requires consideration of three basic factors: population, projected five years; utilization data; and a desirable occupancy factor. This is usually accepted at 80 per cent for general and tuberculosis facilities and at 90 per cent for long-term care facilities. For general hospitals, 10 beds are added to the formula quotient, having the effect of computing lower occupancy rates for areas needing fewer beds.

III

For the first time in the 22 years of Hill-Burton, the Public Health Service studies reflect these changes in bed capacities, conformance or nonconformance, and determination of bed need.

Nationally, there are more than 6,600 nonfederal general hospitals with about 796,000 beds. A third of these beds do not measure up to conformance minimums. There are now about 12,800 long-term care facilities with just over 700,000 beds. Of these, 11,600 are skilled nursing homes with over 600,000 beds. Deficits among these facilities are astonishingly high with five out of six beds either in the nonconforming group or held to be in need of modernization.

There are now more nonfederal tuberculosis facilities and beds than are deemed to be needed. Some 296 of these facilities have over 46,000 beds against a formula-derived need for 260 facilities with just over 40,000 beds.

The studies show, surprisingly enough, that 900 *fewer* general hospitals will be needed five years hence, but there is a need for thousands of additional beds. This demonstrates the impact of facilities planning and consolidation.

On a state-by-state basis, existing general medical and surgical beds average 409 per 100,000 population. The low is in Alaska with 238 beds and the high is in North Dakota with 556 beds per 100,000 population. Because of its aggressive Hill-Burton construction program, Mississippi stands near the top with 414 beds per 100,000 population, among which 348 are deemed to conform to all need. This is far above the national mean.

IV

Clearly, the trend is toward the larger hospital with increased care capabilities, and various state plans support this assertion. California plans increases in the average size of general hospitals from 120 to 186 beds; Georgia, from 92 to 121; Michigan, from 143 to 257; and New York, from 199 to 254.

The increase in intensive care units, specialized care capabilities such as coronary units, and larger outpatient departments suggest that the old progressive patient care concept is entering a new and highly refined state. Strides are being realized in the technology of hospital equipment, and despite the rapidly mounting costs of machines and devices, the capability increase generally warrants their acquisition.



"For some strange reason, Mrs. Plotts, your husband isn't fighting for his life."

In a sense, the emphasis on hospital services is strongly qualitative. And to realize maximum potential from this new and added emphasis, it is vitally necessary for the health care team to function efficiently and harmoniously. The state medical association believes that the addition of practicing physicians as voting members of hospital governing boards will improve liaison between trustees and medical staff. Roles must be clearly defined and authorities and responsibilities, clearly delineated. It can only result in a better day for the patient.—R.B.K.

Troubled Times for Title XIX

Title XIX, popularly called Medicaid, is having troubles, and American medicine is becoming more and more concerned that the program, initially implemented to help those who need help, could become a less-than-adequate means of reaching only part way to this goal. New regulations issued by the government put pressures on professional compensation and impose a new form of utilization review.

The American Medical Association has made a strong protest about all of this, because the regulations on fees are based on payments received by physicians with no consideration being given to usual and customary fees. Taken in another light, AMA pointed out that since Medicare—as opposed to Medicaid—payments are 80 per cent of the usual, customary, and reasonable charge, this amount could become the maximum of every charge.

Further, AMA contended, were physicians to receive less than full payment for their services and write off losses, the reduced payment scale could become the basis for "reasonable" charges under Medicaid.

The argument against new utilization review requirements for every item of service under a Title XIX program, including those rendered in a physician's office or in the patient's home, said they could lead toward national standards authorizing treatment for each medical condition limited in a manner set by regulation.

Many states have found themselves on difficult days with Title XIX programs, in almost every case from a financial standpoint. It is not a cheap program, as the state medical association has repeatedly said in its series of regional information conferences last year and often in print. Mississippi is moving toward Title XIX, and it is critically important that the program be fully medically oriented, soundly structured, and adequately financed. In the meanwhile, the government has the responsibility of living up to the spirit as well as the letter of the law.—R.B.K.

Postscript to the Postgraduate Study

With this issue of the JOURNAL, the five-part series on the study of postgraduate and continuing medical education in Mississippi is concluded. It was published in five consecutive issues, beginning in July, immediately following approval of the research project by the House of Delegates at the 100th Annual Session.

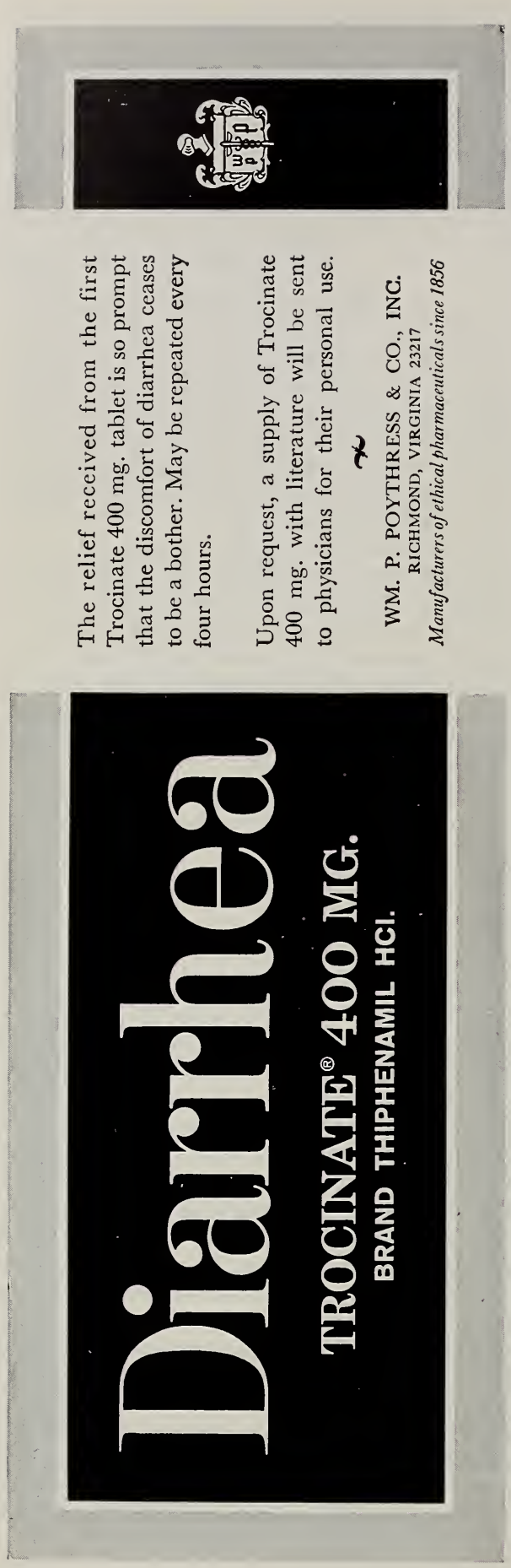
A number of developments arising out of the study and the series itself merit comment. The project, a 10-months endeavor by the Council on Medical Education, was unique in that it opened an entire new field of activity for the state medical association. While studies have been made on many occasions in the past, none previously undertaken approached the magnitude of the postgraduate education inquiry.

Second, the project was supported in part financially by the Regional Medical Program of the University Medical Center, underscoring the partnership in Mississippi medicine. More than that, the study demonstrated the depth of expertise which is latent in the association's councils and committees. This is a vital resource too often overlooked in the past.

Still another happy and fortuitous spin-off was the series of articles adapted from the technical and sometimes dry study report. Not only did this assure the indexing of the work in the formal literature of medicine but it also placed the meat of the findings and conclusions in the hands of the real owners, the members of the association.

Two gratifying and encouraging developments have occurred since publication and release of the study report last May. The University Medical Center has received full accreditation of its postgraduate and continuing education program. It is one of the first 20 major medical institutions in the United States to be so accredited. The importance of program accreditation was emphasized in the study, because physicians do not wish to invest their time in postgraduate study which is less than the best.

A second development came about in the Re-



gional Medical Program in the apponitment of a special subcommittee on continuing medical education for practicing physicians. When it was announced that the state medical association had been invited to name three members, President Rogers appointed Drs. Dennis E. Ward of Corinth, Frederick E. Tatum of Hattiesburg, and Guy T. Vise of Meridian. Drs. Ward and Tatum are members of the Council on Medical Education, while Dr. Vise, a past president of the association, sits on the body as a member of the Board of Trustees.

The entire enterprise is one which the association can view with satisfaction, and the challenges posed in the study conclusions will open many doors in this worthy service to the clinician.—R.B.K.

More Seniors Mean More Medical Demands

Among the many facts and figures which the 1970 census will tell us, one can be clearly anticipated. This relates to our senior citizens who, by reason of continued medical advancement, are living longer and becoming a larger part of the total population each year.

Today, there are almost 19 million Americans over age 65, a gain of more than 2.2 million since April 1960. The insurance actuaries predict that by 1975, there will be 21 million seniors and by 1985, an astonishing 25 million.

The 65-to-69 years of age bracket is the fastest growing segment in the population of the aging, and it is recording an increase of about 15 per cent every decade. But the growing span of human life reaches into every age segment, including a notable increase of almost 10 per cent in the 75 year old bracket.

Everyone knows that women tend to live longer than men, and this disparity of sex is widening. Today, there are 2.6 million more elderly women than men. By 1975, the difference will be 3.5 million, and the actuaries predict that by 1985, the gap will stand at 4.6 million.

Today at age 65, about 25 per cent of the men are still in the labor force, as opposed to less than 10 per cent of the women. Familial characteristics may have some bearing on this, because more senior males live in family groups than do elderly females. The latter, obviously by their longer life, tend to be more frequently widowed.

All of these demographic statistics suggest that Medicare could become a program of staggering proportion, what with increasing care costs over and above a substantially increased reservoir of beneficiaries. This growing segment of the population will also place new demands upon providers of medical services who, in turn, will have more to offer as the years pass. The challenge of the aging is apparent in many areas with a major thrust upon medicine.—R.B.K.

Home Accidents and Product Safety

There's no place like home to get injured or even killed, the grim statistics prove it beyond a doubt. Last year, the U. S. Public Health Service recorded more than 4 million home accidents, 30,000 of which were fatal. Nearly a quarter of a million involved washing machines, power lawn mowers, and stoves. Over 4,000 related to glass doors, and the list continues.

Comes now the National Commission on Product Safety, a creation of the 90th Congress, which will investigate just how safe the gadgets we buy and use in the home really are. The initial list carries 250 classifications of home appliances, electrical devices, tools, furniture, machines, and even things for baby.

The commission says that only 30 per cent of the manufacturers making home products have any quality controls. It cites such tragedies as a 13-month-old baby hanging himself on a musical toy designed for amusement in the crib.

A Brawley, Calif., eight-year-old was electrocuted with a portable hair dryer, and hardly a week goes by that the press fails to report suffocation of a child in an abandoned refrigerator or freezer which cannot be opened from the inside.

The commission hopes to stimulate safety consciousness among industrial trade associations, design improvements in home products with safety in mind, and general voluntary regulatory standards among manufacturers which will make our gadgets safer to use.

The commission plans a series of open hearings next year, claiming that unyielding manufacturers will be named. The possibility of litigation is real.

Obviously, the voluntary way is the preferred way in a climate of free competition. And it is also pertinent to note that no manufacturer can foolproof a product against foolish use.—R.B.K.



THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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POSTGRADUATE CALENDAR

PEDIATRICS VISITING LECTURER

Dr. Weston Kelsey, Department of Pediatrics chairman at Bowman-Gray School of Medicine, will be the Southern Medical Association's visiting professor of pediatrics at the University Medical Center November 7 and 8.

"Thyroid Problems in Children" is his 4 p.m. talk in Room 7-A November 7 and "Production of Physicians' Assistants" is the 1 p.m. address November 8 in the School of Nursing auditorium.

NEWER APPROACHES TO PRACTICAL PROBLEMS IN RESPIRATORY DISEASE

University Medical Center, Jackson
December 4, 1968, beginning at 9:30 a.m.

Sponsored by the Mississippi Regional Medical Program and the University of Mississippi School of Medicine

Participants:

Roger Mitchell, M.D., Director of Pulmonary Diseases, Department of Medicine, University of Colorado School of Medicine

John F. Busey, M.D., clinical professor of medicine, University Medical Center

Guy D. Campbell, M.D., clinical associate professor of medicine, University Medical Center, and coordinator, Mississippi Regional Medical Program

Ellis M. Moffitt, M.D., clinical assistant professor of medicine, University Medical Center

Graham B. Shaw, M.D., clinical assistant professor of medicine, University Medical Center

Myra D. Tyler, M.D., Director of Pulmonary Research, and acting assistant professor of medicine (part-time), University Medical Center

Friday Morning

All That Wheezes Is Asthma
Dr. Moffitt

Management of Positive Tuberculin Reactions
Dr. Campbell

Pink Puffers and Blue Bloaters
Dr. Mitchell

Friday Afternoon

Respiratory Failure
Dr. Shaw

Pulmonary Embolism
Dr. Tyler

Pulmonary Fungal Diseases Seen in Mississippi
Dr. Busey

Modern Tuberculosis Management
Dr. Mitchell

Do It Yourself Session

FUTURE CALENDAR

November 1 and 8, 1968
Circuit Course, Tupelo

November 4-8, 1968
Strokes and Related Neurological Diseases



"How am I supposed to cough with that heavy weight on my chest?"

November 7, 1968
CIRCUIT COURSE, GREENWOOD

November 7 and 8, 1968
DR. WESTON M. KELSEY, BOWMAN-GRAY SCHOOL OF MEDICINE, SOUTHERN MEDICAL ASSOCIATION VISITING PROFESSOR OF PEDIATRICS

November 8, 1968
CARDIOPULMONARY RESUSCITATION TRAINING COURSE

December 4, 1968
CHEST DISEASES SEMINAR

January 13-17, 1969
STROKES AND RELATED NEUROLOGICAL DISEASES

January 8, 15, 22, 1969
CIRCUIT COURSE, BILOXI

January 9, 16, 23, 1969
CIRCUIT COURSE, HATTIESBURG

January 24, 1969
DERMATOLOGY SEMINAR

January 28, 1969
CIRCUIT COURSE, COLUMBUS

February 18, 1969
CIRCUIT COURSE, NATCHEZ

February 19, 1969
SYMPOSIUM ON HUMAN SEXUALITY

February 25, 1969
CIRCUIT COURSE, COLUMBUS

March 4, 1969
CIRCUIT COURSE, MERIDIAN

March 7, 1969
KIDNEY SEMINAR

March 71-21, 1969
STROKE AND RELATED NEUROLOGICAL DISEASES

March 26-28, 1969
CARDIOVASCULAR SEMINAR

April 1, 1969
CIRCUIT COURSE, MERIDIAN

April 15, 1969
CIRCUIT COURSE, NATCHEZ

April 22, 1969
CIRCUIT COURSE, COLUMBUS

May 6, 1969
CIRCUIT COURSE, MERIDIAN

May 12-15, 1969
MISSISSIPPI STATE MEDICAL ASSOCIATION

PERSONALS

J. M. BLOUNT, JR., of Philadelphia is a candidate for election as trustee of the Neshoba County Board of Education, District 1. The election of school trustees occurs on Nov. 5 during the general election.

HUGH B. COTTRELL and ERIC A. MCVEY, JR., both of Jackson, have been respectively welcomed to the capital city as State Health Officer and director, Hinds County Health Department, by the Jackson Chamber of Commerce. The special occasion was sponsored by the chamber's Committee on Medical and Dental Affairs.

WAYNE G. ELLIOT has joined the staff of the Vicksburg Hospital where he will be engaged in the practice of pathology. He is a graduate of the Louisiana State University School of Medicine, and he interned at Southern Pacific General Hospital in San Francisco. Dr. Elliot received his specialty training at the New Orleans Charity Hospital, and he is a diplomate of the American Board of Pathology. During 1966-68, he served as an Air Force medical officer.

BEN J. KITCHINGS of Long Beach has qualified as a candidate for the city's Board of Aldermen as a Republican. He has been serving as vice chairman of the local party committee and is a director in the Long Beach Chamber of Commerce.

HOWARD A. NELSON of Greenwood has been named general chairman of the Leflore County United Givers Fund for 1968-69. Dr. Nelson is a past president of the state medical association, the University of Mississippi Alumni Association, and the Greenwood Chamber of Commerce. He currently serves as Delegate to AMA.

GUY P. SHARPE, JR., has been elected chief of staff at the Greenwood Leflore Hospital. Serving with him for the 1968-69 year are JOHN F. LUCAS, JR., vice chief of staff; and EUGENE F. WEBB, secretary-treasurer. Named to the executive committee were S. G. MOUNGER, chairman; HOWARD A. NELSON, and CLYDE SMITH. All staff officers are from Greenwood.

FRANK K. TATUM of Tupelo, director of the Lee County Health Department, was featured in the first program segment of a new ETV series on channel 9, WTWV. The series considers child growth and development. Dr. Tatum's topic was prenatal care.

C. D. TAYLOR, JR., of Pass Christian, was re-elected chief of staff at Memorial Hospital at Gulfport. Dr. Taylor also serves as chairman of the state medical association's Board of Trustees. Named to serve with the new staff organization are E. T. RIEMANN, JR., vice chief of staff, and ROBERT A. LITTLE, secretary-treasurer, both of Gulfport.

JAMES T. THOMPSON of Moss Point qualified as a Democratic candidate for the Jackson County Election Commission in District 2. He is a past president of the state medical association and currently serves as a member of the Judicial Council.

W. W. WALLEY of Waynesboro has been awarded a certificate of merit through his Rotary Club. The certificate was issued by the Dictionary of International Biography of London and cites the honoree for his "civic and Christian activity."

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

ABRAHAM, WADIE HILL, JR., Meridian. Born Meridian, Feb. 21, 1934; M.D., University of Mississippi School of Medicine, Jackson, 1960; interned Letterman Army Hospital, San Francisco, California, one year; obstetrics and gynecology residency, Brooke Army Hospital, Ft. Sam Houston, Texas, Sept. 1, 1961-Aug. 31, 1964; elected Aug. 6, 1968 by East Mississippi Medical Society.

LOTT, RAMON CLYDE, Columbus. Born Tylertown, Oct. 28, 1934; M.D. University of Mississippi School of Medicine, Jackson, 1960; interned Medical Center, Columbus, Georgia, one year; elected Sept. 10, 1968 by Prairie Medical Society.

DEATHS

WATSON, WILLIAM T., Water Valley, M.D., Memphis Hospital Medical College, Memphis, Tennessee, 1909; died Sept. 22, 1968, aged 87.

AMA Will Stress Health Planning

Community health planning—the who, what, when, and how—will be the theme for the American Medical Association's National Conference on Community Health Planning, Nov. 30, in Miami Beach.

Case histories of health planning activities at the state and local levels will be presented during Saturday morning's opening session. These presentations will reflect a variety of goals and approaches as developed in light of local circumstances.

The afternoon program will be devoted to multiple workshops designed to provide a thorough orientation to the actual process of planning—how a community goes about organizing for health planning, assessing needs and resources, defining goals and alternative solutions, and establishing action programs.

The one-day conference is sponsored by AMA's Board of Trustees and the Council on Medical Service and will be held at the Hilton Plaza Hotel.

DVM's Name New Association Officers

Dr. John L. Durr of Jackson was inaugurated president of the Mississippi State Veterinary Medical Association at the group's recent annual session. Named president-elect was Dr. Vernon D. Chadwick, also of Jackson.

The new secretary-treasurer is Dr. James R. Kerr of Biloxi, and executive board members include Drs. Daniel M. Thomas of Forest and Jack B. Ross of Jackson. Dr. Homer C. Moody of Poplarville was named vice president.

Continuing to serve as executive secretary is Dr. Harvey F. McCrory of Mississippi State University.

State Association Contracts to Perform Major Research Project for Mississippi

The Mississippi State Medical Association has concluded an agreement with the Office of the Governor to perform a major study on health information systems. Schedules call for completion of the research project by Jan. 31, 1969.

This was the announcement of Dr. Joseph B. Rogers of Oxford, president, and Dr. C. D. Taylor, Jr., of Pass Christian, chairman of the Board of Trustees, who said that "this is the largest single study and research task yet undertaken by the association."



Dr. Alton B. Cobb, director of the Division of Comphehensive Health Planning in the Office of the Governor, left, discusses the association's research project with Dr. C. D. Taylor, Jr., chairman of the Board of Trustees.

The work will be presented to the Governor's office through the Division of Comprehensive Health Planning headed by Dr. Alton B. Cobb of Jackson.

Drs. Rogers and Taylor explained that a health information system is a body of data which should be continuous, comprehensvie, standardized, and interrelated. They cited a hospital's medical records system as a typical example. It is estimated that there are hundreds of health information systems being maintained in the state, usually independently of one another and almost always without coordination or interrelationship.

The study seeks to identify and classify these systems, discover who is maintaining and using the data so collected, and how it can be best utilized by practicing physicians and other health care team members for the benefit of patients.

At its recent meeting, the Board of Trustees reviewed proposals on the study in detail and approved it. The association will be compensated by the state of Mississippi for costs incurred in performing the study, Dr. Rogers and Taylor said.

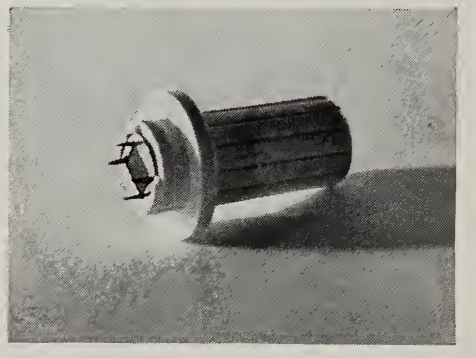
By categorizing and classifying information systems, making a systems inventory, engaging in systems analysis, recommending goals and alternatives, and suggesting means by which the state, within its capabilities, may achieve better health care programs, the study can and should contribute to a sound Title XIX program.

It is also known that the study will become one of the major elements in preparing for the special session of the legislature in 1969 when action on Title XIX is anticipated.

Drs. Rogers and Taylor said that the association will furnish an advisory body from among the association's leadership and which is also representative of the disciplines in the scientific sections. The agreement with the Governor's office

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Make tuberculin testing routine with every physical examination.



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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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provides for consultants whose specialized knowledge may be required in the research.

For some years, the association has called for a reappraisal of the hodge-podge of fragmented health care programs under a number of state agencies. Study of information systems will relate closely to such programs and point toward the goal of eliminating duplication and improving effectiveness.

The association has recently been increasing its study and research activities. Earlier in the current year, a major study of postgraduate and continuing medical education in Mississippi was made in partnership with the Regional Medical Program of the University Medical Center. Other studies in past years have covered various fields of interest among a number of councils and committees of the association.

In addition to staff training and experience, a major factor in the association's capability for performing studies and research is in its having an IBM data processing system and trained programmers. Most such studies involve substantial arrays of data.

The health information systems project will be published during January and submitted as the final study report to Dr. Cobb, the association spokesmen said.

Nominations To Come Early in 1969

Under a new procedure adopted by the House of Delegates at the 100th Annual Session, nominees for election to office in the Mississippi State Medical Association will be selected prior to the 101st Annual Session, May 12-15, 1969, and announced to the membership a month before the conclave.

The procedure involved a change in the By-Laws on the nominating procedure as well as the tenure of service of the Nominating Committee, a body of the House of Delegates. The new requirement calls for naming the committee to serve a year, and it is mandatory that it meet to make selections at least three months prior to the annual session at which nominees will be voted on.

Committee members are also obliged to consult with their colleagues locally and determine if prospective nominees are willing and able to serve, if elected.

Present members of the committee named last May by the House of Delegates are Drs. B. B. O'Mara of Biloxi, chairman, District 9; E. LeRoy Wilkins of Clarksdale, District 1; James O. Gil-

(Reprinted from Blue Cross-Blue Shield's current advertising campaign)



FRANK SUMRALL, GENERAL MANAGER, RADIO STATION WAML, LAUREL, MISSISSIPPI, AND PRESIDENT OF THE MISSISSIPPI BROADCASTERS ASSOCIATION SAYS.....

"We have only 9 employees but we enjoy broad health care coverage... just like the big boys!"

"Even though we employ only 9 people in our operation, we make sure they have the same kind of coverage for health care as that chosen by most of the nation's really big businesses – Blue Cross-Blue Shield. Blue Cross-Blue Shield is ideal for the small business, because it reduces the paperwork in an office. In fact, my secretary says she would quit if we did not have Blue Cross-Blue Shield. Our employees are really happy with the coverage, too. It's Blue Cross-Blue Shield all the way for us!"

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more of Oxford, District 2; Thomas W. Wesson of Tupelo, District 3; and S. Lamar Bailey of Kosciusko, District 4.

Other members are Drs. J. A. K. Birchett of Vicksburg, District 5; C. B. Mitchell, Jr., of Meridian, District 6; C. R. Jenkins of Laurel, District 7; and W. Moncure Dabney of Crystal Springs, District 8.

The slate of officers to be named for 1969-70 include the president-elect, vice presidents, editor, an associate editor, AMA delegate, alternate AMA delegate, and members to fill vacancies occurring on the councils on Budget and Finance, Constitution and By-Laws, Medical Education, Legislation, Medical Service, and the Judicial Council.

Vacancies occurring on the Council on Scientific Assembly to include all section chairmen and some secretaries will be filled by the respective section members.

Three seats on the State Board of Health come up for voting, and these are Public Health Districts 2, 4, and 5.

Association spokesmen said that detailed listings of the vacancies to occur in office will be sent to component medical societies of the association and to members of the Nominating Committee. Every member who holds elective office in the association is furnished an annual listing of his election or re-election and the expiration date of his term of office.

Coast Physician Is Honored by RVN

Dr. John B. O'Keefe of Ocean Springs has been awarded a certificate of commendation by the Minister of Health of the Republic of South Viet Nam. Dr. O'Keefe served in the war-beseiged republic as a volunteer under the AMA-USAID program.

During his tour, the Gulf Coast orthopaedic surgeon was located in My Tho, a provincial capital 40 miles west of Saigon in the Mekong Delta. He served in a 400 bed civilian hospital.

Dr. O'Keefe practiced general medicine for six years at Biloxi before entering his residency at the New Orleans Charity Hospital. He is a medical graduate of the Tulane University. He has served both as an Air Force line officer in World War II and more recently as a Navy medical officer.

Under the AMA Volunteers for Viet Nam, physicians elect to spend a 60 day tour in one of 18 provincial hospitals in South Viet Nam. About 30 physicians are needed each 60 days for the program which is managed and sponsored by AMA and financed by the U. S. Agency for International Development.

Dr. O'Keefe is a member of the Coast Counties Medical Society, the state medical association, and AMA.

UMC Addition Nears Completion

The new 154 bed addition to the University Medical Center is nearing completion and will raise the capacity to 490 beds from the present 350 level.

One hundred beds are included in the new circular pediatric addition. The design concept, widely employed in new hospital construction, reduces corridor communications distance and raises efficiency of nursing service, architects say.

Also included are 54 private rooms for adult



Inspecting progress on construction of the new UMC hospital addition are, from the left, Theodore Waldrom, physical plant director; D. Andrew Grimes, associate director of University Hospital; Dr. Blair Batson, professor and chairman of pediatrics; and Morris Phillips, State Building Commission field supervisor.

The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

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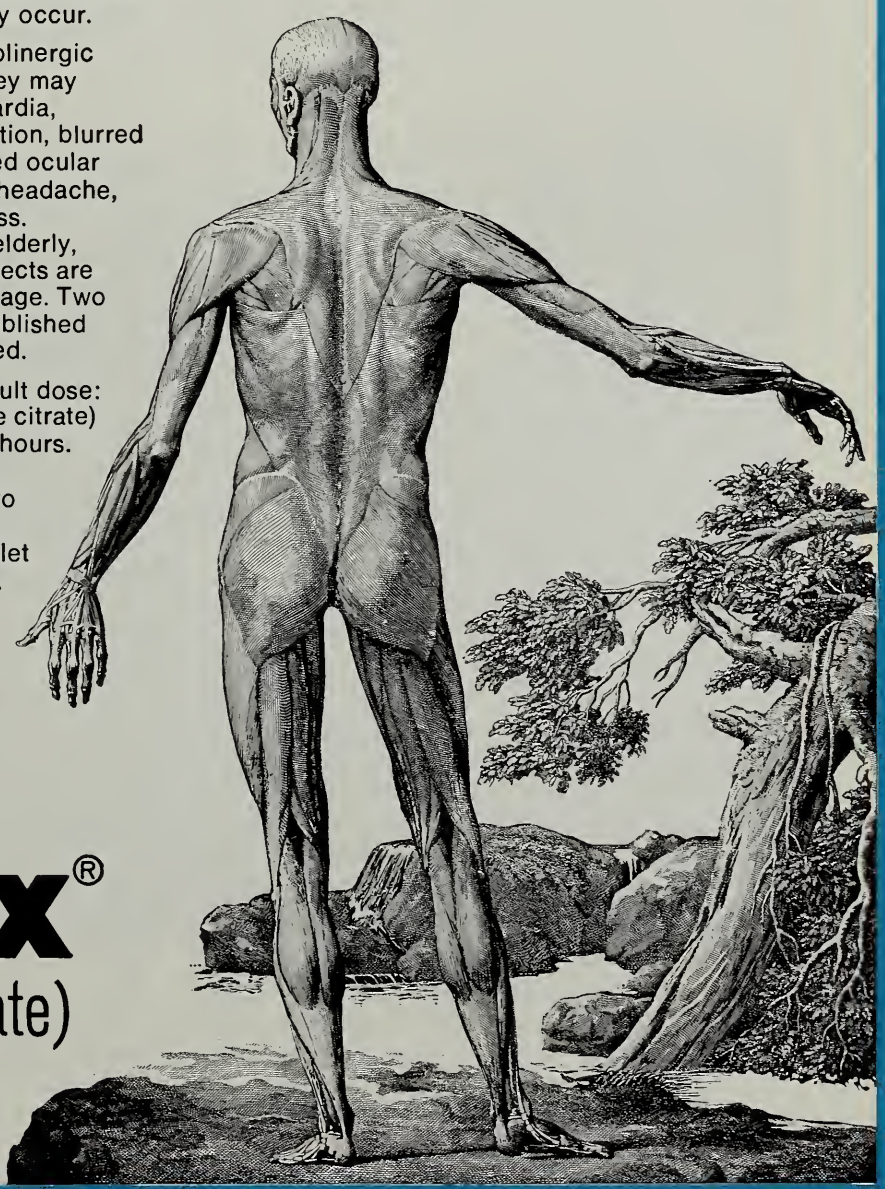
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

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patients in a conventional floor plan. The addition to the UMC complex features a new entrance and lobby area for private patients, new admitting area, new physicians' lounge, and additional parking for the clinical faculty.

Construction of the $3 million addition was begun in 1966 and is now nearing completion.

Central Is Cited for EMCU Service

The membership of the Central Medical Society, the association's largest component body, was singled out for high commendation by the Board of Trustees for service in the Emergency Medical Care Unit during the recent 1968 Regular Session of the Mississippi Legislature.

Speaking for the association leadership, Drs. Joseph B. Rogers of Oxford, president, and C. D. Taylor, Jr., of Pass Christian, chairman of the Board of Trustees, said that members of the Central furnished 21 Doctors of the Day and 74 days of on-call service in the unit.

The EMCU was established in 1964 as a public service of the association to furnish care for members of the legislature and its immediate staff. On each legislative day, the unit, located on the fourth floor of the New Capitol at Jackson, is open with a full-time registered professional nurse and a volunteer Doctor of the Day.

Three members of the Central, all Jackson physicians, were additionally commended in the action of the Board of Trustees. They are Drs. J. Daniel Mitchell, T. A. Baines, and John P. Buckley, Jr. Dr. Mitchell served as DOD and gave 16 days of on-call service. Dr. Baines served 12 days on-call, and Dr. Buckley served six days.

Following up on the formal action of the Board, a letter of commendation to the society has been presented by Dr. Rogers and Dr. Taylor.

During the record-breaking 1968 session, the legislature met from Jan. 4 through Aug. 4 with *sine die* adjournment on Aug. 9. The Central Medical Society carried the major portion of the medical service duties through its members. The Trustees also commended the North Central District Medical Society which furnished eight DOD's, placing second to Central, with the Delta and East Mississippi societies close runners-up.

Ila G. McCleave, R.N., of Jackson was EMCU nurse. Mrs. McCleave has served with the association in the care unit since its inception in 1964.

Drs. Rogers and Taylor said that 436 visits were recorded during the 1968 session to the care unit. Upper respiratory conditions were the most commonly diagnosed condition. Other conditions seen by the DOD ranged from headache, contusions, one hematoma, to four heart episodes, two of which were fatal.

Cost of the unit, largely the compensation for the professional nurse, totaled slightly over $2,800 for the recent session. The funds are appropriated by the House of Delegates from general funds of the association.

Both the House of Representatives and the Senate adopted resolutions commending the state medical association for the service.

NCI and VA Open Oncology Service

A new National Cancer Institute-Veterans Administration Medical Oncology Service has been established at the Washington, D. C. Veterans Administration Hospital. The service will function both as a part of the medicine branch of the National Cancer Institute, National Institutes of Health and the Washington, D. C. Veterans Administration Hospital Medical Services.

This collaboration is viewed by both the National Cancer Institute and the Veterans Administration as an excellent example of cooperative efforts between agencies for the enhancement of both programs and furthering of mutual aims including the best of patient care.

Dr. Kenneth M. Endicott, Institute Director, said the new Service reflects the growing importance of drugs in cancer treatment. The unit will serve as a focal point for the Institute's expanding research program on lung cancer and certain other forms of cancer. Dr. Oleg S. Selawry, formerly Chief of Chemotherapy at St. Jude's Children's Research Hospital, Memphis, Tennessee, will head the new Service.

The Service will plan and conduct clinical trials with new and established anticancer drugs and investigate the activity of new agents. It will also evaluate the possible role of the body's defense mechanisms in influencing the survival time and response to treatment of patients with lung cancer. In addition, Dr. Selawry and his associates will join investigators from other units of the National Cancer Institute's Clinical Trials Area in a study of cell kinetics in patients with solid tumors.

A 30-bed facility at the VA Hospital will be devoted to the cancer chemotherapy studies. At

the present time the unit has two senior investigators, a junior physician and a VA staff physician, in addition to Dr. Selawry.

State Cancer Society Names New Officers

Dr. M. Beckett Howorth of Oxford has been installed as president of the American Cancer Society, Mississippi Division, for the 1968-69 year, and Dr. James P. Spell of Jackson has been named president-elect.

Elected to the office of first vice president was Dr. A. E. Brown of Columbus and area vice presidents include Mrs. J. T. Latham of Eupora, Mrs. Edwin Boyce of Yazoo City, Dr. Glen T. Pearson of Hattiesburg, and Dr. E. E. Bramlitt of New Albany.

Francis J. Lundy of Jackson was elected chairman of the board of directors of the society, and Dr. Guy T. Gillespie of Jackson is chairman of the executive committee.

Other leaders for the new year are Ralph Hester of Jackson, chairman of the budget and finance committee; William Farlow of Jackson, secretary; Dr. Daniel T. Keel of Brookhaven, chairman of the service committee; and A. Ray Tillman of Jackson, assistant treasurer.

Dr. Richard G. Burman of Gulfport was named chairman of the professional education committee; Joseph Carson of Meridian is the new public information chairman; and Mrs. Warren C. Jones of Forest is chairman of the public education committee.

Charles E. Bailey of Jackson was elected treasurer, and Alvin P. Flannes of Jackson is 1968-69 chairman of the annual crusade committee. Miss Lucille Russ of Jackson is executive director of the division.

The officials were elected at the recent annual meeting of the division at Jackson. Dr. James D. Hardy of Jackson, professor and chairman of the department of surgery at the University Medical Center, discussed "Recent Trends and Developments in Cancer Treatment." Dr. Warren N. Bell of Jackson, UMC clinical laboratories chairman, spoke on "Recent Trends and Developments in Cancer Research."



New officers of the Mississippi Division, American Cancer Society, are seated from the left, Dr. James P. Spell, Mrs. J. T. Latham, Mrs. Edwin Boyce, Dr. M. Beckett Howorth, and Ralph Hester. Standing from the left are William Farlow, Dr. Daniel T. Keel, A. Ray Tillman, Dr. Richard G. Burman, Joseph Carson, Mrs. Warren C. Jones, Charles E. Bailey, and Dr. Guy T. Gillespie, Jr.

AMA Honors Viet Nam Volunteer

Dr. Tom H. Mitchell of Vicksburg has been honored by the American Medical Association for his volunteer service in South Viet Nam last spring. At the October meeting of the West Mississippi Medical Society, he was presented with an illuminated plaque commending him for "humanitarian service."

The presentation was made by Dr. Howard A. Nelson of Greenwood, senior AMA delegate from Mississippi, who represented medicine's parent body. Dr. Nelson was accompanied on his visit to the society by Dr. Gerald D. Dorman of New York, president-elect of AMA.

Dr. Mitchell served in South Viet Nam in a civilian hospital under the AMA-USAID program from March until May. He described the experience as difficult and rewarding. He was the first Mississippi physician to volunteer under the program which requires about 30 physicians every 60 days.

Dr. Mitchell is currently chairman of the state medical association's Committee on Nursing. He is past president of the Mississippi Academy of General Practice and former secretary of his component medical society.

New Society Sets Charter Day

Nov. 6 has been set as charter day for the new Singing River Medical Society. It is expected that Jackson County physicians who make up the new component will be joined on the occasion by colleagues of the Coast Counties Medical Society and a number of state association officials.

The new society was approved by the Board of Trustees and House of Delegates at the 100th Annual Session after Jackson County physicians had petitioned for chartering of the unit. The initial membership will include about 50 physicians.

Preparing for the new component, which will formally come into being on Jan. 1, 1969, Jackson County organizers have adopted a provisional constitution and by-laws and have begun other work aimed at perfecting the structure of the society.

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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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American Cyanamid Company
Pearl River, New York 10965

359-8

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

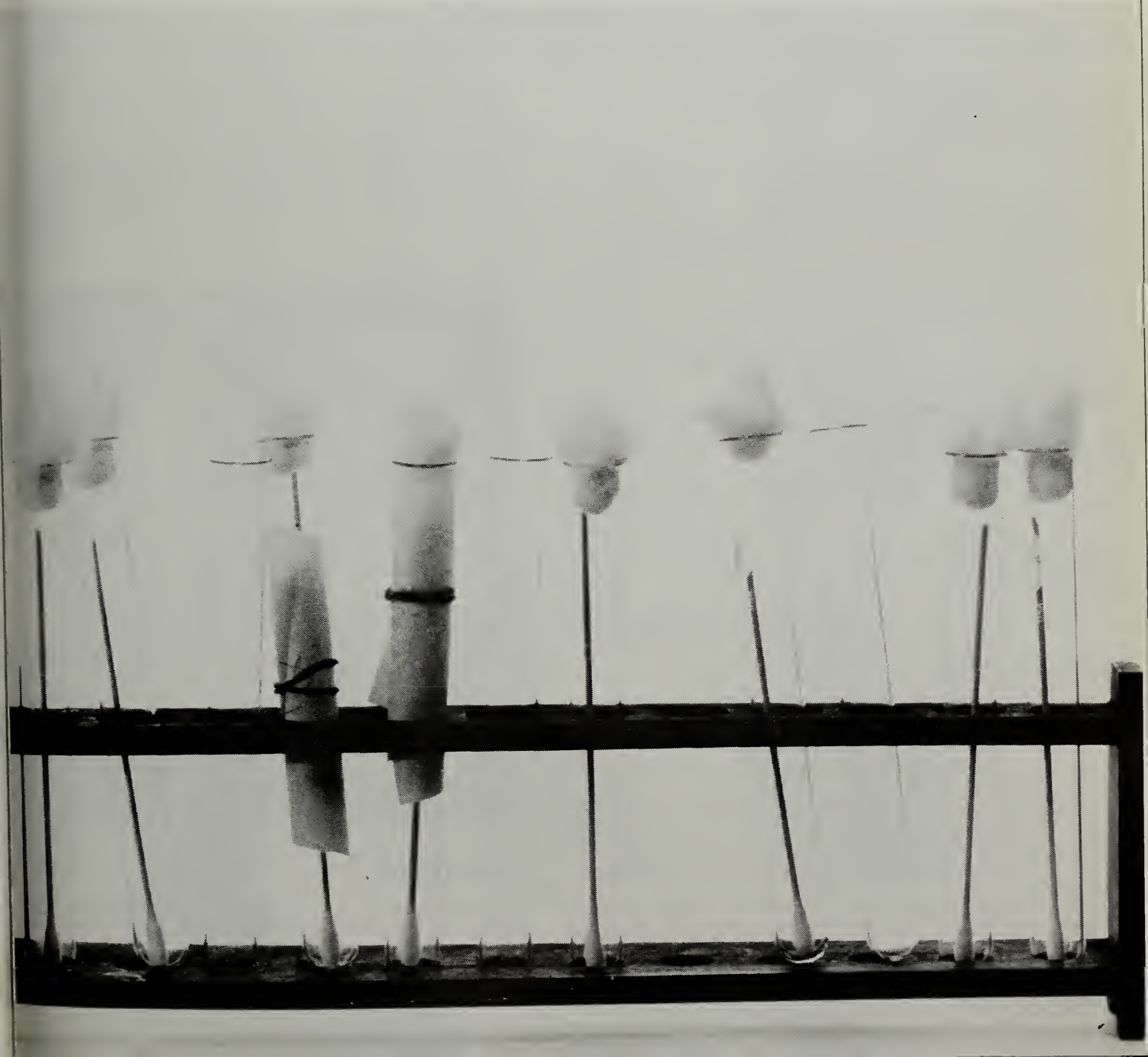
Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

←Prescribing Information

ACHROMYCIN® V
TETRACYCLINE

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The price differential is inconsequential.



Gulfport Aide Is Named AAMA Trustee

Mrs. Anna Ward of Gulfport was elected trustee of the American Association of Medical Assistants. The election took place during the association's 12th annual convention held at Columbus, Ohio.

In addition to serving as a delegate to two national conventions, Mrs. Ward is currently president of both her state and local associations. She has been a member of the education and general convention committees for her state association.

Mrs. Ward is employed as office manager and executive secretary for Dr. Edmund H. Crane, Jr., an internist.

AAMA is a national, professional organization comprised of nearly 13,000 medical secretaries, technicians, nurses and others who work under the direct supervision of a doctor of medicine. Among its major goals is to increase the education and professionalism of medical assistants.

Eli Lilly Makes Label Change

Labels of Eli Lilly medicines for human use will begin appearing late this year with a new professionally approved design featuring greater clarity and legibility. The design also gives new prominence to the Lilly name.

In announcing the change, Eugene N. Beesley, Lilly president, said: "The red script Lilly is being moved from the bottom of the label to near the top. This reflects our long-held and often-expressed belief that the identification of the manufacturer is all-important because it fixes the responsibility for the product's quality—or lack of it."

Since the outward appearance of drugs gives little or no clue as to their quality, the need for identifying the producer is even greater, Beesley believes.

"Because we have a philosophy of excellence," he said, "we intend to put our symbol of excellence where no one can miss it."

The redesigned labels bear the red script Lilly on a white rectangular background, outlined in black and centered on a pastel green stripe across the top of the label. The rest of the label is white, and product names are in black block letters.

In a survey of 357 physicians, dentists, pharmacists, and other health team members to compare designs, the new label rated particularly high for clarity and legibility.

Because a total of some 4,000 Lilly labels will be revised, the changeover is expected to extend through most of next year.

The new design will eventually replace over 90 per cent of the various colored labels now used to identify Lilly drugs. However, labels on certain items with specific color identification requirements—such as Iletin® (Insulin, Lilly)—will not be changed.

In the design, provision was made for the addition of national drug code numbers if such numbers are established.

The Lilly company took the lead in drug identification in June, 1966, when it put an Identi-Code® (formula identification code, Lilly) on each tablet and capsule. In an emergency, a drug's identity and composition can be quickly determined by reference to a widely distributed Identi-Code index.

In March, 1967, another forward step was taken by the Lilly company with the introduction of unit-dose packages for hospital use, which carry the identifying label to the bedside of the patient as a further safeguard. This special package has the trademark Identi-Dose® (unit dose medication, Lilly).



New Lilly label, right, shows clarity and high legibility over old.

...even though antihypertensive agents like rauwolfia-thiazides no longer work to your satisfaction. Something more potent is needed. And there's one therapy you should always consider for blood pressure that's escaping control...something that includes guanethidine. Esimil.

Why? Because Esimil offers guanethidine tempered with hydrochlorothiazide. Adding hydrochlorothiazide makes guanethidine easier to handle, hypertension easier to control. Esimil minimizes undesirable side effects, because doses of components are smaller than would be necessary if either component were used alone. And Esimil is simple to administer—usually just one or two tablets once a day.

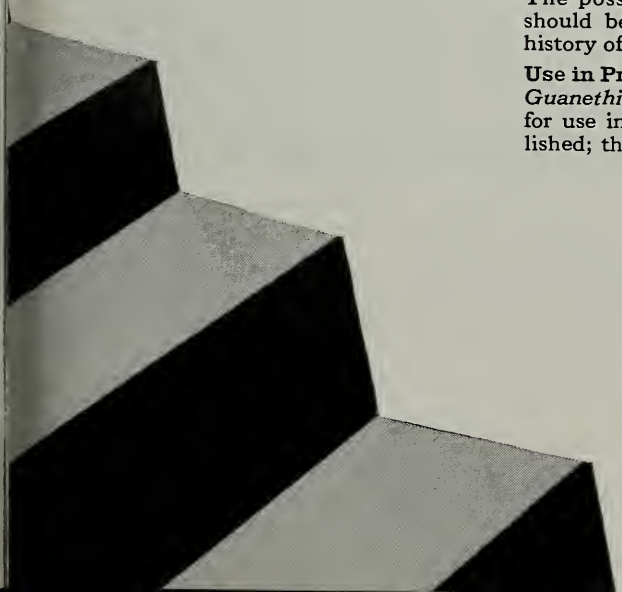
With Esimil you can usually lower blood pressure to the level you want. And it will probably stay there—development of tolerance is rare with Esimil.

So when a rauwolfia-thiazide combination is no longer effective, Esimil could be just what the patient needs.

The antihypertensive of tempered potency

Esimil®

guanethidine monosulfate 10 mg
hydrochlorothiazide 25 mg



ESIMIL®

guanethidine monosulfate 10 mg
hydrochlorothiazide 25 mg

INDICATIONS

Hypertension which cannot be adequately controlled with simpler agents; moderate to severe hypertension; sustained hypertension; almost all forms of fixed and progressive hypertensive disease; when side effects of other antihypertensives prevent effective treatment.

CONTRAINDICATIONS

Guanethidine: Proven or suspected pheochromocytoma; hypersensitivity to guanethidine. Do not use with MAO inhibitors.
Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Guanethidine: Orthostatic hypotension may occur early in treatment, on arising, during hot weather, and after alcohol, prolonged standing, or exercise. Caution patient to sit or lie down with the onset of weakness or dizziness.

Concurrent use with rauwolfia derivatives may cause bradycardia, mental depression, and postural hypotension.

Withdraw therapy 2 weeks prior to surgery if possible to reduce hazard of cardiac arrest or arrhythmia. If not, administer preanesthetic agents, anesthetics, and vasopressors cautiously in reduced dosage with oxygen and atropine ready for immediate use.

Febrile illness may reduce dosage requirements.

Due to catecholamine depletion and increased responsiveness to norepinephrine, special care is required when treating patients with a history of bronchial asthma.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Titrate dosage carefully in patients with impaired renal or hepatic function or nitrogen retention; discontinue thiazides if progressive insufficiency is observed.

Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by uricosuric agents.

Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine. Hypotensive episodes under anesthesia have been observed; decrease dosage of preanesthetic and anesthetic agents.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Guanethidine: The safety of guanethidine for use in pregnancy has not been established; therefore, this drug should be used in pregnant patients when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in breast milk. Thus, adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Guanethidine: Give cautiously to patients with severe coronary insufficiency, recent myocardial infarction, or cerebrovascular insufficiency and with extreme caution in those with severe congestive failure. Peptic ulcers and some other chronic disorders may be aggravated by guanethidine.

Appetite suppressants (amphetamines) and mild stimulants (*eg*, ephedrine, methylphenidate) may decrease the hypotensive effect of guanethidine.

Wait one week after discontinuing MAO inhibitors before starting guanethidine.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and nonrigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Guanethidine: Dizziness, weakness, lassitude, syncope, bradycardia, increase in bowel movements, diarrhea, inhibition of ejaculation, fluid retention, edema, congestive heart failure. Less frequently: dyspnea, fatigue, nausea, vomiting, nocturia, urinary incontinence, dermatitis, scalp hair loss, dry mouth, rise in BUN, ptosis of the lids, blurring of vision, parotid tenderness, myalgia, muscle tremor, mental depression, chest pains (angina), chest paresthesias, nasal congestion, weight gain, and asthma in susceptible individuals.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, muscle spasm, weakness, restlessness, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE

Optimal dosage must be determined for each individual. *Note:* 10 mg guanethidine monosulfate present in Esimil is equivalent to 8.4 mg guanethidine sulfate USP (Ismelin®).

SUPPLIED

Tablets (white, scored), each containing 10 mg guanethidine monosulfate and 25 mg hydrochlorothiazide; bottles of 100.

Before starting therapy, consult complete product literature.

CIBA Pharmaceutical Company
Summit, New Jersey

2/3714-R1

CIBA

CAP Announces 1969 Quality Survey

The College of American Pathologists has announced its 1969 comprehensive survey program to maintain strict quality control in medical laboratories. The announcement from CAP said that specimens and data are available to members by series.

Specimens developed and produced by Hyland Laboratories meet specifications of the college, the announcement said. With each is adjunctive data, and many have computer print-outs of values and refree lists of values by method.

The program has been developed to enable pathologists to evaluate their own methodologies and procedures, to maintain strict quality control, and to assure best results in behalf of patients. The college's survey program is the largest such continuous project in the world.

To date in 1968, more than 428,000 specimens have been sent to 4,000 participants in the United States, and 35,000 specimens were sent abroad.

Subscription fees for survey series are nominal, averaging only 90 cents per specimen.

Programmed Technic Is New Anesthesia Trend

A technique that permits anesthesia to be administered to the patient by an automatic programmer has been developed by University of Chicago anesthesiologists.

Drs. Harry J. Lowe and Hoon T. Kye said the system is based on calculating the weight of the patient's organs, the amount of anesthetic dissolved in the different organs and the quantity of blood flow normally going to these organs.

It is possible by this means to calculate in advance the anesthetic requirements for each patient, said the report presented to the American Society of Anesthesiologists.

The requirements of the individual are plotted on a curve-follower, connected to the syringe pump which, in turn, injects the liquid anesthetic into the anesthetic circuit by means of an automatic programmer and maintains the infusion until the patient reaches the desired concentration of anesthetic.

This eliminates the need to administer to the patient large quantities of anesthetic at the outset, Dr. Kye explained. The programmed technique meets all blood and tissue requirements as needed. It is all calculated on a curve, once the patient is put to sleep, the blood level is held at a constant concentration by replacing what the tissues take out of the blood.

The curve is plotted for a 220-pound person. If a 132-pound person were the patient, the rheostat is turned down to 60 per cent of the dose.

MHA Set Stroke Rehabilitation Meets

The Mississippi Heart Association has announced three area workshops on the team approach to stroke rehabilitation sponsored by the Community Heart Programs Committee.

Dr. Eugene M. Murphey, III, of Tupelo, stated the program will focus attention on special needs of the stroke patient. Participating in the program will be: Dr. Robert D. Currier, associate professor and chief of the division of neurology, University Medical Center; Dr. William J. Gillespie, Jr., supervisor, heart disease control unit, Mississippi State Board of Health; Mrs. J. Robert Snavely, nutritionist; Mrs. Elizabeth Graves, associate professor, school of nursing, University Medical Center; Mrs. Zona Jelks, public health nursing; Miss Marylin Reynolds, physical therapist; and Miss Marie Hoffman, social service, University Medical Center, Jackson.

The dates for the workshop are Oct. 31 at Oxford; Nov. 12 at Jackson; and Nov. 14 at Hattiesburg.

Dr. Lewis Gets Post With Wyeth

A Mississippi physician has been named associate director of medical communications of Wyeth Laboratories. Dr. Earl T. Lewis, formerly in private practice in Simpson County and a native of Hattiesburg, was named to the newly created post, according to Dr. Daniel L. Shaw, medical director of the major pharmaceutical manufacturing organization.

Dr. Lewis is a graduate of Millsaps College, and he received his medical degree from Jefferson Medical College at Philadelphia. His residency in internal medicine was completed at the University Medical Center.

Duties of the position will place Dr. Lewis in close contact with the practicing profession.

Pfizer Offers New Quality Control Service

A new computerized analysis service has been introduced by the Pfizer Diagnostics Department of Chas. Pfizer & Co., Inc., to simplify quality control in hematology testing and make it a practical routine for all clinical laboratories regardless of size or location.

Designated the Statistical/Numerical Analysis Program (SNAP), the service permits laboratories throughout the United States to submit hematology quality control data to a Pfizer computer center for complete monthly statistical analysis. As a result, participating laboratories need only accumulate quality control data on a daily basis and are relieved of tedious and time-consuming calculations which require up to one day per month.

Quality control in clinical laboratories is recommended and endorsed by professional societies, and is required by Medicare. It improves accuracy and precision, helps evaluate and maintain laboratory proficiency, and provides vital confidence limits for physicians. According to Pfizer Diagnostics, SNAP will be an important aid in establishing quality control procedures in the hematology laboratory.

The SNAP program is free of charge to laboratories using Pfizer's standardized quality control reagents for hematology testing. They include Celltrol,* a reference control for red blood cell counts and hematocrits; Leukotrol,* a reference control for white blood cell counts; and Globintrol,* a reference control for hemoglobin determinations.



Herbert J. Kleiman, marketing manager of Pfizer Diagnostics, right, and John G. Cronin, systems analyst at Pfizer, review hematology quality control data after it is processed by an IBM 360 Digital Computer.

Under the SNAP program, participating laboratories record data each day using the Pfizer hematology control reagents. The data is then submitted to Pfizer Diagnostics at the end of each month on a special postage-paid SNAP input form for analysis by an IBM 360 Digital Computer System. In approximately seven to 10 days, each laboratory receives a SNAP report indicating the calculated mean, standard deviation, and coefficient of variation for its red and white blood cell counts, hematocrits, and hemoglobin determinations at both normal and abnormal levels.

With the SNAP data, laboratories are able to interpret their performance for the control period just completed and establish control limits for future control periods.

RCA Sells Medical Electronics Subsidiary

The sale of its medical electronics activity for approximately $1 million to Hoffmann-LaRoche, Inc., Nutley, N. J., has been announced by RCA.

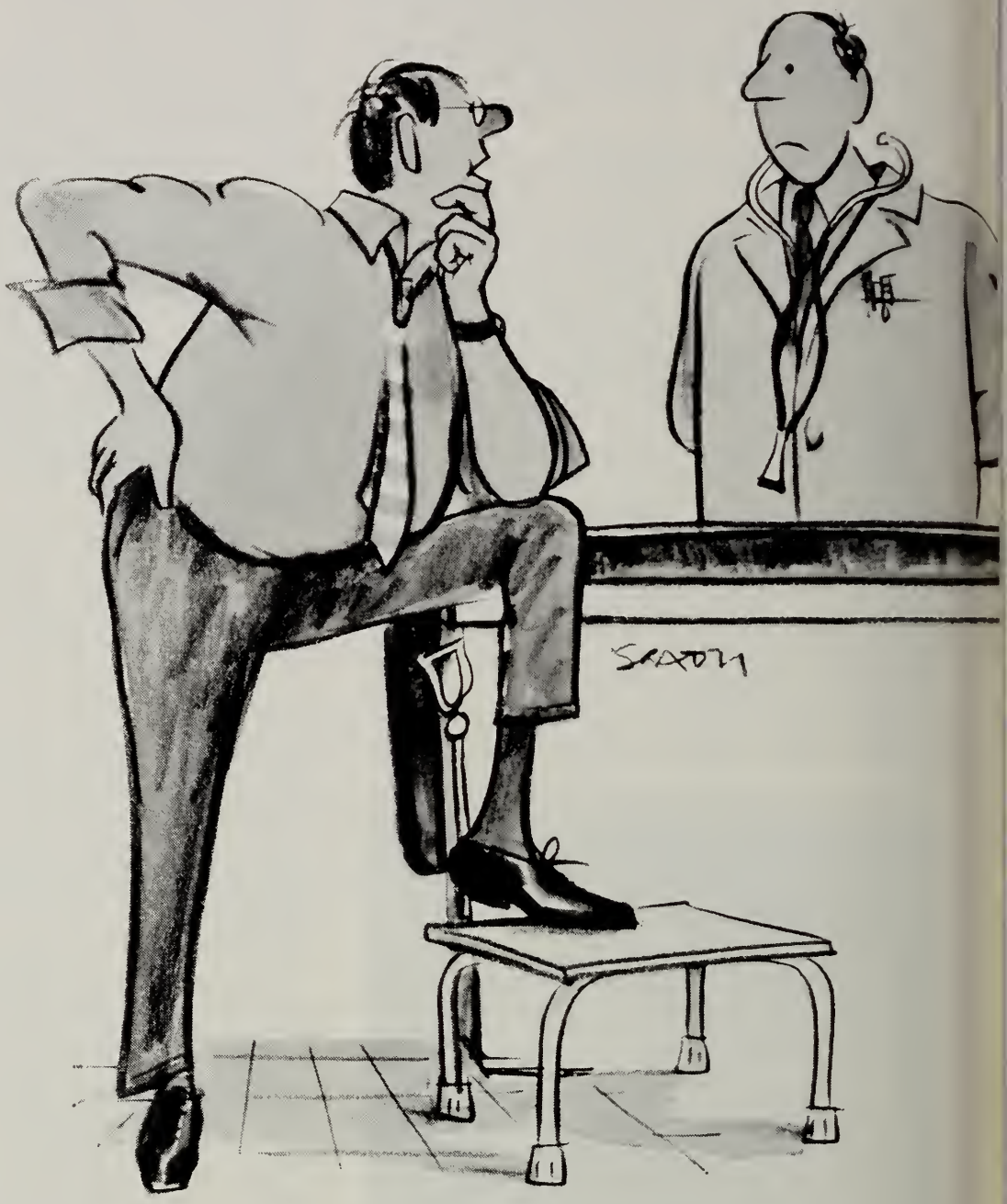
RCA will continue to sell medical support equipment such as computer systems, closed-circuit TV and radio networks to hospitals and medical centers. It will also continue its servicing activities in the installation and maintenance of such equipment.

In addition, RCA will pursue the development of medical system applications such as multitest mass screening, medical education, and systems linking RCA's broad capabilities in video, computers and communications into new forms of highly integrated medical information systems.

The transaction terminates an agreement between RCA and Hoffmann-LaRoche announced in May 1966. Under this agreement, the two companies collaborated in the development, production and marketing of new and advanced medical devices.

RCA and Hoffmann-LaRoche decided that this joint project could best be advanced under one roof and one management. Hoffmann-LaRoche intends to continue the work of the former RCA medical electronics activity with the same personnel in the same physical laboratory facilities in Trenton, N. J.

* Registered Trademark of Pfizer.



Nothing else I've tried seems to work, so I decided to give you a crack at

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.)

Sustained Release Capsules

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Pearl River, New York

407-8

MRMP, UMC Offer Stroke Care Course

The Mississippi Regional Medical Program and the University of Mississippi School of Medicine will offer an intensive refresher course on the care of strokes and related neurological diseases Nov. 4-8.

Attendance is limited to four practicing physicians who will be accepted in the order in which their applications are received. Course content will stress the fundamentals of the management of the acute stroke patient and involve extensive physician participation in the day-to-day care of patients in the MRMP demonstration unit at the Medical Center.

Mississippi Regional Medical Program grant funds will reimburse successful out-of-city applicants for travel costs, lodging and subsistence in Jackson during the course, as well as for instructional materials.

PMA Protests Nelson Report

A subcommittee of the U. S. Senate has developed distorted and misleading "evidence" in order to create a climate of public acceptance for price control legislation on prescription drugs, the Pharmaceutical Manufacturers Association has charged.

"This data is a sorry commentary on both the calibre of the investigation and on the lengths to which the vendetta against the drug industry is being carried," C. Joseph Stetler, PMA president, said in attacking the methods of the Monopoly Subcommittee of the Senate Small Business Committee, whose chairman is Sen. Gaylord Nelson (D-Wis.).

Stetler's statements concerned a study conducted by the subcommittee staff on drug purchasing by representative cities and counties across the country. The study was made a part of the record of the hearing on December 19 of last year.

"Of the 128 pieces of price information presented, more than 80 per cent is either flatly wrong, invalid, or grossly misleading," he declared. "Even where the numbers are literally correct . . . the public is led to assume things the facts do not support."

This is the second time the PMA has undertaken "the long and tedious process of backtracking on charges and tracing them to their real or imaginary sources," he noted. In the first instance, William Haddad of New York presented "evidence" of variations in price which he claimed were paid by 12 cities or counties. "We produced irrefutable evidence that the witness had grossly misinformed the Subcommittee," Stetler said. "However, neither the Senator nor his staff have ever attempted a factual refutation of the PMA findings which exploded the veracity of Mr. Haddad's testimony. Nor, of course, have they placed PMA's findings . . . in the hearing record."

The second subcommittee study, which the PMA regards as replete with flaws and errors, involves a query of 77 cities and counties involving 39 drug products.

"Sen. Nelson said that 29 communities responded . . . but when he announced the results of the survey, he referred only to data from 21 cities on 17 drugs," Stetler said.

The PMA's three-month study, the PMA executive reported, found that the Subcommittee survey ignored differences in purchasing power, and differences in purchases from wholesalers and from manufacturers. In addition, it made invalid comparisons of products from different manufacturers.

Stetler said the Subcommittee study paid no attention "to the differences that are bound to occur when you pit the modest purchasing power of a single retirement home in Iowa against that of, say, the Army, Navy, Air Force and Marines combined."

"The survey also hides the fact that some smaller communities' purchases were made from wholesalers or certainly not from manufacturers, while the purchases being contrasted were made direct," he said. "Thus, this kind of allegation results in triple distortion: drug manufacturers are blamed for selling to a city they did not sell to; and they are indicted for a price they did not charge. And that price, which in one case was an indirect purchase involving six bottles, was compared with a price paid by the City of New York (to a manufacturer) for five thousand bottles."

In a wide-range attack on the Subcommittee methods, Stetler also said that Senator Nelson has yet to call on numerous expert witnesses who could testify on various medical and scientific questions which have been raised. He listed these as the American Medical Association, the American Academy of General Practice and more than 20 other organizations and individuals who have asked for appearances "and to this day are all still waiting to testify."

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MIC Approves New Program Region

The Mississippi Interagency Commission has announced that it has established an additional mental health-mental retardation program planning region, bringing the total number in the state to 15.

The M.I.C. is the state agency for coordination of regional program planning for the mentally ill, mentally retarded, alcoholics, and others.

The new region was created by dividing Region 11, which formerly included eleven counties of Southwest Mississippi. The division keeps Amite, Jeff Davis, Lawrence, Lincoln, Marion, Pike and Walthall in Region 11 and creates Region 15, composed of Adams, Franklin, Jefferson and Wilkinson counties.

Dr. Dorothy Moore of Jackson, program director for the M.I.C., said the reorganization had been requested by regional representatives "who cited the size of the area and the distance between major population centers as being a deterrent to effective planning."

A minimum population of 75,000 and a maximum of 200,000 is required for a planning area to qualify for federal assistance in construction or staffing of a mental health center. The new Region 11 has a 1970 projected population of 136,000, and Region 15 has a projected population of just under 75,000, with population expected to exceed 75,000 by the time an official project is submitted by the region, according to Dr. Moore.

A 1966 state law provided for establishment of multi-county mental health-mental retardation planning regions, with each region authorized to establish a planning commission composed of members appointed by boards of supervisors—one member per county, serving a four-year term. Seven regions have established official planning commissions. In some of the other regions, one or more commissioners have been appointed and are awaiting action by supervisors of other counties.

The law authorizes the regional commissions to request boards of supervisors for special tax levies not to exceed two mills "for the construction, operation and maintenance" of facilities for the mentally ill and mentally retarded. A mental health complex in Tupelo now serves Region 3, consisting of seven counties in Northeast Mississippi, and a $1,800,000 center for Region 9 is being planned by St. Dominic's Hospital in Jackson. Other regional commissions are preparing

plans for additional programs.

The M.I.C. is composed of the chief executive officers of the five state agencies with major responsibilities for programs related to mental illness and retardation. These agencies, with their chief executives, include the State Board of Health (Dr. H. B. Cottrell), Board of Education (Dr. Garvin Johnston), Welfare Department (Arthur Winstead), Board of Mental Institutions (Seth Hudspeth) and Board of Trustees, Institutions of Higher Learning (Dr. E. E. Thrash). Hudspeth is chairman.

The State Board of Health is responsible for community services and prevention, and the Board of Mental Institutions administers state institutions for the mentally ill and the retarded. The Board of Education oversees vocational rehabilitation and special education, and the Welfare Department provides related social services. Mental health and mental retardation professionals are trained by institutions under the Board of Trustees, Institutions of Higher Learning.

New List Is Out on Health Agencies

The sixth revision of AMA's Directory of National Voluntary Health Organizations has been released. The biennially published reference source is for informational purposes.

AMA, as is true of the state medical association, neither approves nor disapproves of voluntary health agencies.

The new edition of the directory lists the purpose, organizational pattern, financing, and programs of the various naitonal voluntary health groups. Examples are the American Heart Association and American Cancer Society.

AMA formally defines a voluntary health agency as "any nonprofit association organized on a national, state, or local level, composed of lay and professional persons, dedicated to the prevention, alleviation, and cure of a particular disease, disability, or group of diseases and disabilities.

"It is supported by voluntary contributions primarily from the general public and expends its resources for education, research, and service programs relevant to the disease and disabilities concerned."

Single copies of the new directory may be obtained by writing the Council on Voluntary Health Agencies at the American Medical Association's Chicago headquarters office.



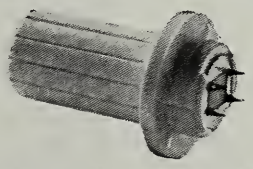
Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

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Tuberculosis? Influenza?
Pneumonia? Leukemia?
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Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

NEWSLETTER

MISSISSIPPI STATE MEDICAL ASSOCIATION

JACKSON, MISSISSIPPI

December, 1968

Dear Doctor:

The first distinguished lecturer sponsored by the C.B. Mitchell Premed Fund at Mississippi State University was Dr. Alton Ochsner. Fund will endow MSU's growing premed program and has goal of funding a distinguished chair at the University.

> Fund is being helped by sale of "golden" railroad spikes from old GM&C tracks which were on campus for 75 years. Dr. John C. Longest heads committee and reports sale of $9,000 in spikes to MSU alumni and friends.

Major medical insurance paid more than $109 million for prescription drugs this year, a 15 per cent increase over 1967. Health Insurance Institute says that better drug coverage is being provided under major medical policies. Most such coverage carries both deductible and co-pay clauses.

Mississippi Economic Council is again offering awards to junior and senior high schools for achievement in physical fitness. Program is designed to encourage participation in physical education by high school students, underscoring qualified instructors, curriculum, academic credit, and programs for handicapped children. Dr. David B. Wilson of Jackson is chairman of MEC committee on project.

Reorganization of the Bureau of Narcotics under the Justice Department has been completed with appointment of a medical director. He is Dr. Edward Lewis, Jr., formerly of Food and Drug Administration and a pharmacologist on Georgetown University faculty.

Medicare payments under Part 1-B in Mississippi show seasonal gains with disbursements hitting close to $850,000 per month. October claims volume exceeded 20,600 with 67.5 per cent assignments to physicians. Summer claims volume was about 18,500 monthly, according to carrier, Travelers Insurance Company.

Sincerely,

Rowland B. Kennedy
Executive Secretary

DATELINE - MEDICAL AMERICA

Alaska Pioneers Glasses Safety Law

Fairbanks - An ophthalmologist-legislator, Dr. Milo H. Fritz, has successfully sponsored a law providing that only safety glasses and sunglasses may be prescribed in Alaska. Measure also prohibits dispensing of eyeglass frames made of combustible materials. Dr. Fritz, formerly a member of AMA House of Delegates from Alaska, says that law is first of its kind in the nation. American manufacturers have largely abandoned use of flammable materials in frames, but imports are not uniformly safe.

Wallace Hospital Construction Is Begun

Decatur - Ground was broken last month to begin construction of the $4.2 million Lurleen B. Wallace Mental Retardation Hospital. New facility is first of four proposed institutions for care of retarded in Alabama, the others to be at Birmingham, Montgomery, and Mobile. Former Gov. Wallace joined Gov. Brewer in ceremonies launching construction.

RMP Offers Dial-Access Medical Library

Madison, Wis. - Physicians of Wisconsin and Minnesota can now dial direct, toll-free to the medical library at University of Wisconsin and hear a five minute magnetic tape on the scientific subject of their choosing. Program is a joint project of Wisconsin and Minnesota Regional Medical Programs, and physicians of the two states have been furnished catalogues of taped subjects and the special In-WATS telephone number.

New York Medicaid Hassle Continues

New York - The Medical Society of the State of New York has issued strong protests over welfare officials' refusing to pay Title XIX Medicaid claims from physicians holding teaching posts in major hospitals and medical schools. State has charged that payments would duplicate salaries and that $25 million in pending claims would constitute a windfall to physicians. Physicians who voluntarily serve as teachers without pay are eligible for payments, society said.

AAMC Reports On Enrollment Expansions

Evanston, Ill. - The Association of American Medical Colleges reports that the nation's medical schools have provided an additional 1,520 first year places since active enrollment expansions began in 1963. Present goals of U.S. medical schools are to provide for progressively bigger freshman classes with a total first year enrollment of 11,000 by 1971.

pinworms in this school?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections which are estimated to occur in from ⅓ to more than ½ of all American children from every social level

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections among primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

When examination reveals pinworm infection—an increasing number of physicians favor treatment with a single, well-tolerated dose of—

Povan®

(pyrvinium pamoate)

PARKE, DAVIS & COMPANY, DETROIT, MICHIGAN 48232

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MEC Will Urge M.D. Civic Service

The Mississippi Economic Council has named a committee of physicians to encourage members of the medical profession to engage in civic activities to a greater degree. Dr. Howard A. Nelson of Greenwood, a past president of the state medical association, has been named chairman.

Paul McMullan of Hattiesburg, chairman of MEC's Budget and Finance Committee announced the program and named the committee.

Other physicians appointed are Drs. Eldon L. Bolton of Biloxi, Frank M. Davis of Corinth, R. Mayo Flynt of Meridian, William A. Middleton of Winona, and Thomas L. Moore of McComb.

Also named are Drs. Charles M. Murry, Jr., of Oxford, R. Carter O'Ferrall of Jackson, Guy P. Sharpe, Jr., of Greenwood, and W. W. Walley of Waynesboro.

Dr. Nelson was quoted by MEC as stating that "we members of the medical profession are aware of the positive forces at work in Mississippi, making it a better place to live and do business. We are also aware that we need more men from our profession involved in this effort."

MEC spokesmen said that a mailing to all physicians will soon be made within the districts represented by the several special committee members. The mailing will solicit support for the intensified program of the council.

Health Reference Is Gift Offer

Few physicians or Auxiliary members would ordinarily think of doing Christmas shopping at the American Medical Association, but AMA is offering an unprecedented holiday gift bargain.

The popular book, *Today's Health Guide,* illustrated in color and by color overlay transparency, regularly selling for $5, may be sent to any addressee in the United States for $2. Orders must be accompanied by check or money order and be received before Dec. 15.

The offer also includes bulk shipment of copies at the same price for local giving. In addition to gifts for individuals, the book is highly suitable for presentation to high school libraries.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-253-2761

Thermography Offers New Diagnostic Tool

Photographs and "temperature maps" of infrared rays from arthritic joints may soon help physicians plot more effective treatment for victims of rheumatoid arthritis, the Health Services and Mental Health Administration has reported.

In an administration-supported research project now taking place at the Temple University School of Medicine in Philadelphia, a heat-detecting instrument, the thermograph, is undergoing extensive evaluation as it measures and records the body-surface temperatures of a group of patients afflicted with rheumatoid arthritis.

Administration medical authorities believe that if thermography is found to compare favorably with current evaluation techniques it will benefit physicians and reduce crippling in two essential ways: It will allow physician-investigators to evaluate new and current treatments by plotting the subsequent progression or regression of the disease, and it will provide a means of detecting rheumatoid arthritis at its earliest possible stages, when crippling is most preventable.

Dr. Glen W. McDonald, Chief of the Administration's Diabetes and Arthritis Control Program, explained that every human body emits infrared radiation.

"If the eye were structured to see this emission," he said, "each of us would have an incandescent glow."

Thermography detects the rays that comprise this glow, converts them to light energy and uses them to expose photographic film. Thermograms, or temperature maps, may then be drawn for medical analysis.

The technique's relevance to rheumatology lies in the fact, long known to medical science, that isolated areas of inflammation emit more heat than surrounding, uninvolved regions. Rheumatoid arthritis is the result of inflammation in the joint lining (synovium).

"We have found that areas of synovial inflammation show heat changes too subtle to detect by touch, yet significant enough to affect the thermograph," Dr. McDonald said. "Such changes indicate excessive cellular or metabolic activity; they can indicate the presence and severity of rheumatoid arthritis."

Hill Crest
HOSPITAL
(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
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Phone: 205-836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 43 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



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James K. Ward, M.D., F.A.P.A.
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HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . .
. . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . .
ALABAMA HOSPITAL ASSOCIATION . . .
BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals and is also approved for Medicare patients.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA



Getting her down presents no problem

Even though rauwolfia-thiazides have failed to give control, chances are her hypertension will respond to Esimil. It offers the potency of guanethidine tempered with hydrochlorothiazide.

He's coming down uneventfully

The addition of hydrochlorothiazide makes guanethidine easier to handle, hypertension easier to control. Doses of components are smaller than would be needed if either component were used alone. Side effects are often minimized.

the antihypertensive of
tempered potency

CIBA

Esimil®

guanethidine monosulfate 10 mg
hydrochlorothiazide 25 mg

She's down to stay

Tolerance rarely develops with Esimil, even after prolonged use. Because an Esimil regimen is easy and convenient (usually just one or two tablets once a day), the patient is less likely to skip medication.



INDICATIONS
Hypertension which cannot be adequately controlled with simpler agents; moderate to severe hypertension; sustained hypertension; almost all forms of fixed and progressive hypertensive disease; when side effects of other antihypertensives prevent effective treatment.

CONTRAINDICATIONS
Guanethidine: Proven or suspected pheochromocytoma; hypersensitivity to guanethidine. Do not use with MAO inhibitors.
Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS
Guanethidine: Orthostatic hypotension may occur early in treatment, on arising, during hot weather, and after alcohol, prolonged standing, or exercise. Caution patient to sit or lie down with the onset of weakness or dizziness.

Concurrent use with rauwolfia derivatives may cause bradycardia, mental depression, and postural hypotension.

Withdraw therapy 2 weeks prior to surgery if possible to reduce hazard of cardiac arrest or arrhythmia. If not, administer preanesthetic agents, anesthetics, and vasopressors cautiously in reduced dosage with oxygen and atropine ready for immediate use.

Febrile illness may reduce dosage requirements.

Due to catecholamine depletion and increased responsiveness to norepinephrine, special care is required when treating patients with a history of bronchial asthma.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Titrate dosage carefully in patients with impaired renal or hepatic function or nitrogen retention; discontinue thiazides if progressive insufficiency is observed.

Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by uricosuric agents.

Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine. Hypotensive episodes under anesthesia have been observed; decrease dosage of preanesthetic and anesthetic agents.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Guanethidine: The safety of guanethidine for use in pregnancy has not been established; therefore, this drug should be used in pregnant patients when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in breast milk. Thus, adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS
Guanethidine: Give cautiously to patients with severe coronary insufficiency, recent myocardial infarction, or cerebrovascular insufficiency and with extreme caution in those with severe congestive failure. Peptic ulcers and some other chronic disorders may be aggravated by guanethidine.

Appetite suppressants (amphetamines) and mild stimulants (*eg,* ephedrine, methylphenidate) may decrease the hypotensive effect of guanethidine.

Wait one week after discontinuing MAO inhibitors before starting guanethidine.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and nonrigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS
Guanethidine: Dizziness, weakness, lassitude, syncope, bradycardia, increase in bowel movements, diarrhea, inhibition of ejaculation, fluid retention, edema, congestive heart failure. Less frequently: dyspnea, fatigue, nausea, vomiting, nocturia, urinary incontinence, dermatitis, scalp hair loss, dry mouth, rise in BUN, ptosis of the lids, blurring of vision, parotid tenderness, myalgia, muscle tremor, mental depression, chest pains (angina), chest paresthesias, nasal congestion, weight gain, and asthma in susceptible individuals.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, muscle spasm, weakness, restlessness, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE
Optimal dosage must be determined for each individual. *Note:* 10 mg guanethidine monosulfate present in Esimil is equivalent to 8.4 mg guanethidine sulfate USP (Ismelin®).

SUPPLIED
Tablets (white, scored), each containing 10 mg guanethidine monosulfate and 25 mg hydrochlorothiazide; bottles of 100.

Before starting therapy, consult complete product literature.

CIBA Pharmaceutical Company
Summit, New Jersey

2/3832-R1

PHS Sponsors NOLA Pulmonary Training

More and better trained pediatricians to deal with chronic lung problems in children is the goal of a new Public Health Service project designed to update medical skills in the pulmonary diseases.

The new PHS project will help support a model pediatric pulmonary disease center in New Orleans merging the pediatric teaching resources of Tulane University School of Medicine with those of the medical schools of Louisiana State University at New Orleans and at Shreveport.

Dr. William W. Waring, medical educator and specialist in pediatric pulmonary disease, will direct the project, financed by a 3-year, $217,000 contract with the Public Health Service's Chronic Respiratory Diseases Control Program.

Tulane and Louisiana State University will strengthen their predoctoral and postdoctoral medical education programs as a result of sharing their pediatric teaching faculty and laboratory facilities and coordinating their pediatric services in Charity Hospital, New Orleans. Clinical fellowships in pediatric pulmonary disease will be included in the expanded educational program.

The use of PHS funds will help augment and expand pediatric pulmonary services in New Orleans and make them available throughout Louisiana and bordering States. A broad program of continuing education now planned for practicing physicians will offer refresher courses over an existing closed-circuit TV network in 14 public and private hospitals. This Statewide coverage will link physicians in rural areas with pediatric advances in the State's modern medical centers.

Many of the child patients participating in the hospital study and teaching demonstrations to be held under the continuing education programs are expected to come from poverty pockets in metropolitan and rural Louisiana.

The New Orleans project is one of four pediatric pulmonary disease centers activated this year with special Congressional funds earmarked for combating chronic respiratory disease in children.

The other three centers now under way are in Washington, D. C., at Georgetown University Medical School; in Los Angeles County, at the University of Southern California Medical Center, and in Philadelphia, at the University of Pennsylvania, Hahnemann Medical College, and Temple University.

Announcing the Thirty-Second Annual Meeting of THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Roosevelt Hotel—March 10, 11, 12, 13, 1969

GUEST SPEAKERS

Henry K. Beecher, M.D., Boston, Mass.
Anesthesiology
Norman D. Nigro, M.D., Detroit, Mich.
Colon and Rectal Surgery
Rudolf L. Baer, M.D., New York, N.Y.
Dermatology
W. H. J. Summerskill, M.D., Rochester, Minn.
Gastroenterology
Edward J. Kowalewski, M.D., Akron, Pa.
General Practice
John G. Masterson, M.D., Hines, Ill.
Gynecology
Ray W. Gifford, Jr., M.D., Cleveland, Ohio
Internal Medicine
Raymond V. Randall, M.D., Rochester, Minn.
Internal Medicine
Wlliam J. German, M.D., New Haven, Conn.
Neurosurgery
Robert A. Kinch, M.D., Montreal, Que.
Obstetrics
John R. Lynn, M.D., Dallas, Tex.
Ophthalmology
A. B. Sirbu, M.D., San Francisco, Calif.
Orthopedic Surgery
Douglas P. Bryce, M.D., Toronto, Ont.
Otorhinolaryngology
A. James French, M.D., Ann Arbor, Mich.
Pathology
Louis Gluck, M.D., Miami, Fla.
Pediatrics
Wilma C. Diner, M.D., Little Rock, Ark.
Radiology
James D. Hardy, M.D., Jackson, Miss.
Surgery
John W. Kirkland, M.D., Birmingham, Ala.
Surgery
Russell Scott, Jr., M.D., Houston, Tex.
Urology

Additional speaker to be announced.

Lectures, symposia, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives. (All-inclusive registration fee—$30.00.)

This program is acceptable for three and one-half (3½) prescribed hours and twenty-eight (28) elective hours by the American Academy of General Practice.

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Disease Factors Challenge Underwriting

A panel of life insurance medical directors has agreed that common diseases and disorders of man may be more significant than first realized and offer some of the most challenging problems to the life insurance underwriter.

Impairments such as peptic ulcer, polyps, vertigo and hiatal hernia are often encountered, the panel agreed, and may develop, or be part of, a more serious condition leading to increased mortality. The panel presentation was part of the annual meeting of the Association of Life Insurance Medical Directors of America in St. Louis.

Panel members included Drs. John O. Alden, medical director, Aetna Life and Casualty; Newell R. Kelly, medical director, Bankers Life Company; Walter A. Reiter, Jr., medical director and vice president, Mutual Benefit Life Insurance Company; and R. J. DiSalvo, vice president, Union Central Life Insurance Company.

The frequency of a peptic ulcer in at least 12 per cent of the population, Dr. Alden said, emphasizes the possibility of complications that could lead to increased mortality.

He told the medical directors that underwriting problems most often occur in "differential diagnosis," and when a decision is made on incomplete or questionable information.

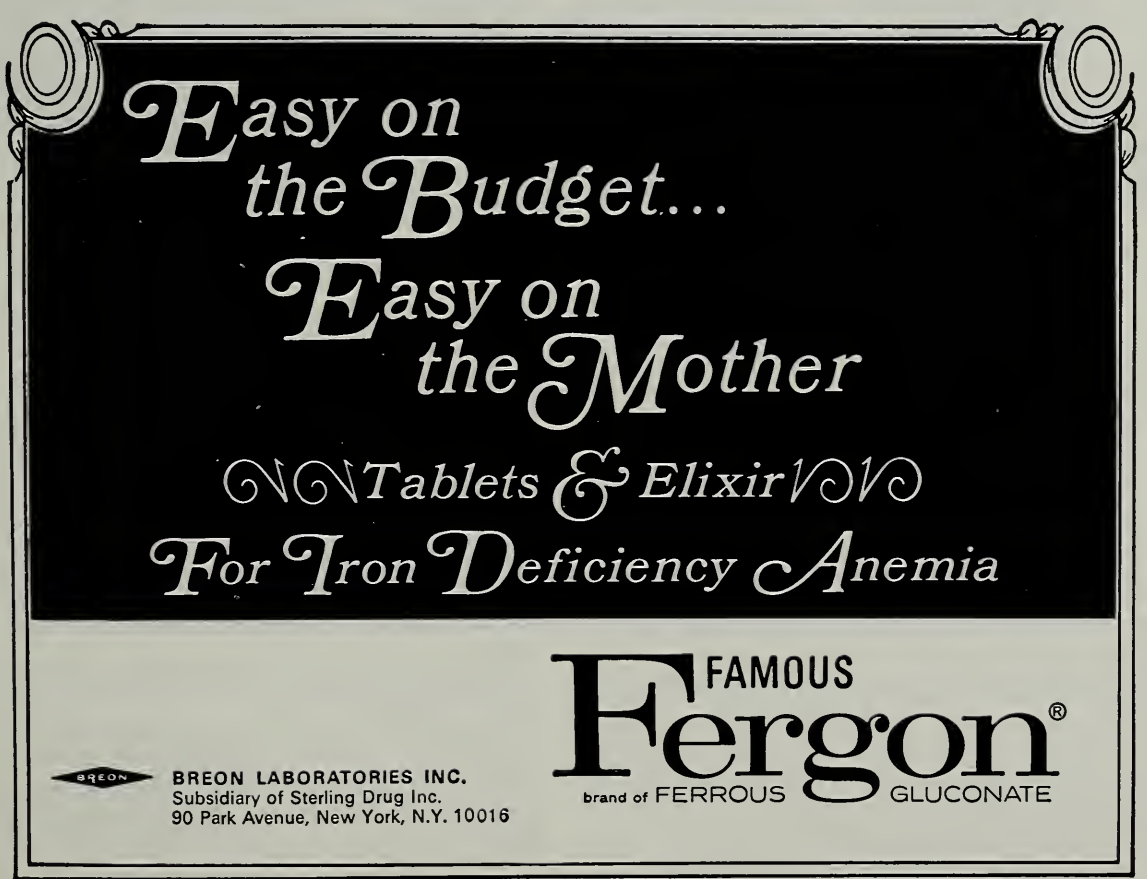
The industry is "very dependent" upon attending physicians when underwriting most gastrointestinal disorders, Dr. Alden said, since the insurance examination provides few significant findings.

He noted that what risk there is arises from the complications of the disease or the surgical treatment the complications may require.

Dr. Kelly, speaking on the varieties of polyps, said that an investigation he made gave no evidence of any adequate mortality study that would help the day-to-day underwriting of polyps.

He said confusion over the tissue structure of polyps was one factor responsible for the varying reports of their actual incidence; a second factor being the clinical sources of the cases studied.

Although Dr. Kelly stressed the use of x-rays and method of treatment in underwriting, he said the real concern of the medical underwriter centers around the relationship of polyps to malignancy, as well as their recurrence.



It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800198

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
December 1968, Vol. IX, No. 12

ORIGINAL PAPERS

A Consideration of the 'Medical' Post-Gastrectomy Syndromes

E. LEONARD POSEY, JR., M.D.
Jackson, Mississippi

A CONSIDERABLE BODY of evidence has accumulated which documents the nature of untoward complications which can appear following gastric resection for ulcer disease (Table 1). Only those conditions which do not have obvious surgical implications will be dealt with in this paper.

The incidence of post-gastrectomy syndromes is unclear and varies from 2-88 per cent in the literature. The statistics depend upon the strictness of criteria imposed as well as the degree of detail applied in the follow-up studies. In a careful survey, Wall and co-workers[1] found one or more definite abnormalities in 83 per cent of 109 unselected patients. The majority of observers report a higher incidence of undesirable residua following a Polya type resection than from a Bilroth I type.[1, 2, 3] I do not believe that an accurate statement can be made relative to the risk of post-gastrectomy syndromes at present, but I am convinced, on the basis of my experience, that it is of sufficient frequency to justify sober consideration preoperatively. These difficulties can prove to be a source of continuing annoyance and, in many instances, virtually disabling. I am also convinced that females are more likely to have trouble than males, that individuals with an asthenic habitus are most prone to develop problems, that psychoneurotics are extremely liable to have lingering postoperative symptoms, and that a Polya type resection is more apt to be associated with adverse effects than a Bilroth I. The nature and degree of complaints will vary markedly from patient to patient and, indeed, in the same individual.

In the literature, the incidence of post-gastrectomy syndromes varies from 2 to 88 per cent, depending on the strictness of criteria and degree of detail. Based on his experience, the author feels that the incidence is of sufficient frequency to justify sober consideration preoperatively. He discusses symptoms and treatment of those conditions which do not have obvious surgical implications.

Symptoms arising during or shortly after a meal are common immediately following surgery, once the patient begins to eat. Should the occurrence persist after the recovery is complete, the patient is considered to have a dumping syndrome. The lack of a functional pylorus, which in effect causes the loss of an effective gastric reservoir, permits rapid gastric emptying, with a

"dumping" of the contents into the jejunum. It is interesting to note that the risk of dumping is directly related to the size of the stoma.[4]

The resultant complaints may be conveniently divided into two categories. Gastrointestinal symptoms include epigastric fullness, bloating, belching, flatulence, nausea, vomiting (occasionally), urgency to stool, and explosive diarrhea (occasionally). Note that pain is not a true component. Vasomotor complaints include tachycardia, palpitation, warmth, pallor and/or flushing, profuse diaphoresis, weakness, dizziness, faintness, desire to lie down and collapse (rarely). Recumbency often relieves the symptoms.

Systolic and diastolic blood pressure are often elevated but occasionally lowered. Electrocardiographic abnormalities of a non-specific nature may be found, consisting of T wave lowering or flattening and S-T segment shifting of a transitory nature. Roentgenologic study reveals a rapid egress of the opaque solution from the gastric remnant. A significant drop in blood volume with a concomitant decrease in cardiac output is a common finding. Hypokalemia is inconstantly documented, as is hyperglycemia. An increased production of serotonin and a sharp elevation of kinin-like plasma activity have been reported. Symptoms do not occur in the absence of rapid gastric emptying with resultant jejunal distention.

TABLE 1

CLASSIFICATION OF POST-GASTRECTOMY SYNDROMES

CLASSIFICATION OF POST-GASTRECTOMY SYNDROMES
A. Surgical
1. Gastric retention
a. Post-vagotomy
b. Narrow stoma
2. Afferent loop syndrome
3. Stomal ulcer
4. Recurrent ulcer
5. Gastrojejunocolic fistula
B. Medical
1. Dumping syndrome
2. Hypoglycemic syndrome
3. Malnutrition
a. Maldigestion
(1) Inadequate "mixing"
(2) Impaired pancreatic secretory stimulus
(3) Impaired bile secretory stimulus
b. Diarrhea
(1) Bacterial overgrowth and migration
(2) Small bowel hypermotility
(3) Uncovered latent malabsorption syndrome
4. Anemia
a. Iron deficiency
(1) Occult bleeding
(2) Impaired iron absorption
(3) Iron binding
b. B-12 deficiency
(1) Impaired B-12 absorption
(2) Gastric atrophy
(3) Bacterial competition
c. Folate deficiency
5. Osteoporosis and osteomalacia

DUMPING SYNDROME FACTORS

In view of the foregoing, it is apparent that a variety of factors may be involved in the dumping syndrome. A brief consideration of their genesis is therefore indicated. It was formerly thought that the presence of hypertonic material in the jejunum was responsible for all of the manifestations of the dumping syndrome. Performance of a standard glucose tolerance test serves consistently as a triggering mechanism. The resultant curve exhibits a marked hyperglycemia at 30 minutes and often descends to significant hypoglycemic levels at two or three hours. Hyperglycemia alone,[5 (a, b, c)] originally considered of etiologic significance, was shown by Machella to be of secondary importance, reflecting the rapid absorption of the large amount of glucose suddenly dumped into the small intestine. Machella's studies[5 (a, b, c)] conclusively demonstrated that distention of the jejunum, whether by a balloon or by hypertonic solutions, was the factor which triggered the dumping attack. Symptoms appeared immediately following distention, prior to the development of hyperglycemia, and were ameliorated with release of distention, even though persisting in a mild form for several minutes.

A variety of hypertonic and hyperosmolar agents have been observed to provoke the dumping syndrome, all by means of producing jejunal distention.[6] Fordtran[7] has shown that hyperosmolar solutions, although not significantly altered intragastrically, are rapidly diluted in the upper small intestine toward a concentration of 300 mOsM/L. This is accomplished by a massive fluid shift transmucosally toward the lumen without a significant electrolyte shift. The large volume of intraluminal material thus acts as the distending agent and serves as the triggering mechanism. Concentrated foods, particularly free sugar and fats are incriminated as notoriously capable of causing the dumping syndrome.

The drop in serum potassium, which has been observed, is not often of symptomatic impor-

tance. The syndrome usually appears well before the appearance of hypokalemia. Material relief is not common with potassium administration. Since hypokalemia develops during the phase of glycogen formation following a glucose tolerance test, it is currently viewed as a normal physiologic phenomenon, and of little etiologic significance.[6, 8, 9] It is important to realize that the intravenous glucose tolerance test is normal in these patients.[10]

In 1954[11] Roberts demonstrated a significant drop in plasma volume after administration of hypertonic solutions to patients following partial gastrectomy but was unable to correlate the symptoms with the phenomenon observed. The studies of Weidner and co-workers[12] extended these findings. In 21 of 31 post-gastrectomy patients, induced dumping was associated with a 6-34.5 per cent decline in plasma volume and a reduction in cardiac output. This abnormality has been well confirmed[6] and is apparently related to the transmucosal fluid shift occurring from the presence of intrajejunal hyperosmolar material.

It was later found, however, that the early symptomatic dumping symptoms appeared prior to the fluid shift. Johnson and co-workers, in 1962,[13] reported that canine portal venous plasma obtained from dogs previously given intrajejunal hyperosmolar material produced the circulatory manifestations of the dumping syndrome in normal dogs after infusion. A humoral agent was suspected. Serotonin was considered likely to be responsible. Serotonin antagonists were found to block the infusion response in dogs, and to at least partially alleviate the symptoms of dumping in patients. Not all symptoms and not all patients are benefited by serotonin antagonists.[14]

INDUCED DUMPING

Zeitlin and Smith,[15] in 1966, could not demonstrate an elevation of whole blood serotonin levels in patients with induced dumping, although they did observe an increase in urinary 5-HIAA output after repeated bouts of induced dumping. They considered the possibility that kinin activation could be the responsible factor, in view of the fact that kinins are known to be responsible for most of the vasomotor manifestations of the carcinoid syndrome, which in many ways resembles the symptoms of the dumping syndrome. In eight symptomatic dumpers, these workers found a sharp, significant increase in plasma kinin-like activity with induced dumping. The mean increase was 37 times greater than controls and was equal to values obtained from victims of the carcinoid syndrome. The rise in plasma kinin coincided with the appearance of the vasomotor symptoms induced. Kinins are biologically active peptides formed from the action of kallikreins (present in various body tissues and released by catecholamines) on kininogen (an alpha-2-globulin). Lysyl bradykinin and bradykinin are among the most potent vasodilators known. In addition to numerous other properties, they possess the ability to stimulate markedly intestinal tone and motility.[16] The possibility that insulin overproduction secondary to the postprandial hyperglycemia present in dumping patients is capable of producing the vasomotor manifestations has been well eliminated.[17]

SEQUENCE OF EVENTS

Here the problem stands. The sequence of events is probably as follows: The rapid emptying of hyperosmolar material induces a massive transmucosal outpouring of fluid which causes jejunal distention. This, in turn, releases catecholamines and possibly serotonin from the gut wall. The catecholamines stimulate kallikrein release, which activates kinins and thus produces the vasomotor symptoms. The intraluminal fluid shift results in a sharp reduction of plasma volume, further adding to the circulatory symptoms. The increased intraluminal volume, coupled with the increase of serotonin and kinins gives rise to the gastrointestinal manifestations. The electrocardiograph changes are probably related to the reduced plasma volume and catecholamine release. The hypokalemia is the normal result of glycogenesis. The hyperglycemia and resultant increased insulin release are of no immediate significance.

The dumping syndrome is obviously complicated in its genesis. Not all facets are completely understood. Why, for example, do some patients exhibit blood pressure elevation, while others manifest hypotension? Why do some patients have primarily gastrointestinal and others largely vasomotor symptoms? What is the relationship and relative importance of the reduction of plasma volume and the increase in kinins? The answers to these and other questions will occupy gastroenterologists for some time to come.

It requires a great deal of time, tact, patience, and understanding of the situation for a physician to cope with this problem. The majority of patients, fortunately, do well if they are willing to adhere to a restricted schedule. The diet should consist of small, dry, frequent meals (to reduce gastric loading), with fluids taken between meals

only; concentrated sweets and fats are strictly forbidden. It is occasionally necessary to have the patient eat in the recumbent position or to assume recumbency after a meal. Sedatives (to allay apprehension) and anticholinergics (to delay gastric emptying) are employed with varying success. Potassium supplementation is only occasionally beneficial but may be worth a trial. Serotonin antagonists are of value in a fair number of patients. The drug which is best tolerated is cyproheptadine, given 30 minutes before meals. Agents which antagonize the kinins have yet to be employed. In the occasional patient who fails to respond to an exhaustive effort medically, it is necessary to seriously consider surgery, either conversion to a Bilroth I anastomosis or an antiperistaltic interposition procedure.

The late postprandial (hypoglycemic) syndrome, which appears 2-3 hours after meals, is of much less severity than the dumping syndrome. The two are not necessarily associated symptomatically. The complaints consist of weakness, tremulousness, hunger, and sweating, with prompt symptomatic relief following ingestion of sugars. A significant hypoglycemia always accompanies the syndrome. There is no relation here to hypokalemia, or increases in serotonin or kinins. Hypokalemia is occasionally present.

POSTPRANDIAL HYPERGLYCEMIA

The mechanism responsible is due to the postprandial hyperglycemia previously mentioned. The high concentration of blood glucose induces a reactive hyperinsulinism which in turn produces the secondary drop in blood sugar, the release of catecholamines, and the appearance of symptoms.[9, 10, 11]

Response to treatment is usually quite satisfactory. The patient is instructed to avoid concentrated sweets at all times. He is placed on a high protein diet and is advised to take protein "snacks" between meals. These measures occasionally fail to suffice. In such instances it is well to recall that the administration of 250-500 mg. tolbutamide before meals is of real value by preventing postprandial hypergycemia from taking place and thus heading off the reactive hyperinsulinism with secondary hypoglycemia.[17]

Where post-gastrectomy malnutrition, diarrhea, and anemia are concerned, it is well to summarize the findings of Wall *et al.*[1] in their survey of 109 patients following gastric resection. Biopsy-proven gastritis was present in 78 per cent, hypochlorhydria in 76 per cent, some degree of anemia in 25 per cent, low serum B-12 levels in 45 per cent, hypoferremia in 33 per cent, hypoalbuminemia in 29 per cent, elevated alkaline phosphatase in 35 per cent, and loss of weight in 47 per cent. The degree of abnormalities was least in patients with duodenal ulcer who had Bilroth 1 type resections and greatest in those with gastric ulcers who had a Polya type operation.

PRODUCTION OF ADVERSITIES

A large number of mechanisms are interrelated in the production of these adversities. They may be summarized as follows:

1. Reduced caloric intake. The small size of the gastric reservoir leads to early satiety and a voluntary reduction of food intake. This is often coupled with a fear of eating (sitophobia) engendered by unpleasant postprandial symptoms.

2. Maldigestion. There seems to be reasonably good agreement that this problem is more common after the Polya operation.[1, 2, 3] The first 40 cm. of the enteron are short-circuited by this procedure—the most active segment of the entire small bowel.[18] This is accompanied by an impairment of the mechanisms responsible for pancreatic stimulation and bile flow;[19, 20] coupled with a significant lack of adequate "mixing" of chyme with digestive secretions,[21] one can easily see that the digestive processes may be materially impaired. The result is an increase in fecal caloric loss and hence weight loss. Absorptive mechanisms are not impaired.[22] Rapid small bowel transit may play a contributory role.[23]

3. Intraluminal bacterial overgrowth. Goldstein, Wirts, and Kramer[24] have shown that the afferent loop may act as a functional "blind loop" and exhibit a marked proliferation of bacteria, including coliform organisms. They further demonstrated the association of this abnormality with post-gastrectomy steatorrhea and its control with the administration of antibiotics. There can be no question that this peculiar situation occurs with some frequency and that it is one of the common causes of post-gastrectomy diarrhea. I have now documented four cases in which bacterial migration and proliferation took place after Bilroth I resections, heavy bacterial counts being obtained from gastric aspirates. The aspirated material was fecal in appearance and odor.

VITAMIN DEFICIENCY

This condition is marked not only by bacterial competition for B-12, leading to a deficiency of this vitamin and all of its consequences, but also by bacterial splitting and de-conjugation of bile

salts. This produces cholate and deoxycholate, both of which exert noxious local effects on the small bowel mucosa and, in addition markedly impair fat digestion and absorption.[25]

4. Abnormal iron metabolism. Several factors may exist singly or in combination to produce a deficiency in the body iron. Duodenal short-circuiting (by-passing this vital absorptive segment) can result in an insufficient quantity of iron being absorbed. Achlorhydria may play a role as well. There is some evidence that abnormal intraluminal iron binding can take place after gastrectomy, interfering with iron absorption. In addition, there is always the possibility of increased iron loss from unrecognized postoperative oozing taking place.[26, 27]

5. B-12 deficiency. As previously mentioned, bacterial competition often leads to a lack of this vitamin. The frequent development of true gastritis, with resultant gastric atrophy, can lead to a loss of intrinsic factor, an inability to bind exogenous B-12, and thus impairment of B-12 absorption, with resultant deficiency.[28]

6. Folate deficiency. The origin of this abnormality is obscure but is apparently related in some way to abnormal iron metabolism.[26]

ENTEROPATHY

7. Unmasked gluten-sensitive enteropathy. Although this is an uncommon occurrence, instances have been reported of apparently normal individuals who, after gastric resection, developed full-blown steatorrhea and who, after investigation, were found to have non-tropical sprue. Apparently the operation serves to tip the scales in these mild and borderline cases to cause them to become manifest.

8. Abnormal intestinal motility. Increased transit time through the small intestine occurs with relative infrequency in these patients, but is of significant import when present.[23] The exact cause is yet to be clarified.

9. Abnormalities in calcium and osseous metabolism. Demineralization of bone is apparently quite rare following gastric resection. The prime etiologic factors are calcium deficiency secondary to the presence of steatorrhea with subsequent intraluminal calcium binding by fatty acids, and hypoproteinemia consequent to malnutrition.[30]

It should be apparent immediately that an accurate etiological diagnosis is imperative for therapeutic success. The various measures employed will be listed, but their usage must depend upon indications. The diet should be high in calories with a high protein content, given as five feedings per day, and with proper regard for the dumping and/or hypoglycemic syndrome. Multivitamin supplementation is certainly indicated. Anabolic steroids may be given with reasonable success in instances of significant weight loss, realizing that these are merely adjuvants. In the presence of hematologic or biochemical evidence of B-12 deficiency, this agent is administered by injection. Ferrous iron is given orally in the usual types of iron deficiency; in the presence of impaired absorption or abnormal iron binding, the material will have to be injected.

ANTIBIOTIC RATIONALE

Antibiotics (tetracycline or ampicillin) are given for control of bacterial migration and overgrowth. In a surprising number of instances it is necessary to continue the drugs one or two days out of the week for a matter of many months in order to prevent a recurrence of the problem once relief is obtained. Gluten is interdicted in the diet in those rare individuals who have an unmasked glutten-sensitive enteropathy. Adrenocortical steroids have been employed with far from constant benefit. Parasympathomimetic drugs have been utilized in patients with small bowel hypermotility, presuming it to be the result of a "Vagal release" phenomenon. I have had much better success with anticholinergics coupled with Lomotil. There will be a rare patient who will not do well despite any and all therapeutic efforts. These will almost certainly be individuals with Polya resections; they will derive benefit, even if not all symptoms disappear, after conversion to a Bilroth 1 anastomosis.

THERAPEUTICS, EDUCATION

It is not the purpose of this paper in any way to denigrate surgery for ulcer disease. Given surgical indications (penetration, perforation, uncontrolled or recurrent hemorrhage, and cicatricial obstruction) there is no modality which can substitute. Indeed, the more compelling the surgical need, the better the postoperative course as far as development of post-gastrectomy syndromes is concerned. On the other hand, physicians must endeaver to improve their therapeutic efforts and must educate patients to properly cooperate and care for themselves if unnecessary surgery is to be avoided. It is inescapably true that the psychoneurotic and the "intractable" patient will do poorly following surgery and will be

complaining with redoubled vigor once the operation is over. ★★★

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HAVANA CORONA

The patient was complaining to a visitor about the cost of his operation the day before.

"What this country needs," he observed, "is a good $50 scar."

—JIMMY WARD *in the Jackson Daily News*

Changes in Laboratory Reporting Of Mycobacteria in Mississippi

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BEGINNING JANUARY, 1969, the laboratory of the Mississippi State Board of Health will report the unclassified (atypical, anonymous) mycobacteria according to species name instead of Runyon group numbers as heretofore.

There will probably be some confusion when practitioners receive a report from the laboratory stating that the sputum was found positive for such organisms as *Mycobacterium scrofulaceum* or *Mycobacterium intracellulare* on culture. It is therefore felt that the following information might prove beneficial.

Over a decade ago, Runyon classified the mycobacterae, other than *M. tuberculosis* and *M. leprae* into four large groups.

These were designated: Runyon Group I (photochromogens), Runyon Group II (scotochromogens), Runyon Group III (non-chromogens), Runyon Group IV (rapid growers).

These have been discussed previously.[1] This rather unwieldly and awkward classification has served fairly well for many years. It was anticipated that eventually each separate organism would be identified and given a species name. As this has come to pass, it is now possible to handle situations arising from the discovery of these specific organisms in a much more scientific manner.

The laboratory of the Mississippi State Board of Health has kept abreast of the progress in methods of identification of the various mycobacteriae. As a result, beginning Jan. 1, 1969, when an organism is definitely identified to be one that has a pathogenic potentiality, it will be reported by species name. Any organism identified as being of a non-pathogenic nature will not be named but will simply be reported by Runyon group as in the past.

It is hoped that the following explanations will aid in handling of problems related to the pathogenic members of non-tuberculous mycobacteriae.

Mycobacterium intracellulare (Battey) in Runyon Group III (nonchromogens): Reported in conjunction with *M. avium* as mentioned below, this is by all odds the most frequently encountered mycobacterium (except *M. tuberculosis)* in Mississippi and the southeastern part of the country. It is felt to be closely related to *M. avium*. In fact, it is not possible to distinguish between the two organisms by the methods now used in our laboratory. Therefore, they will be reported as *"M. avium-M intracellulare"* on the laboratory form. *M. intracellulare* is the original "Battey" organism. *M. avium* will be largely disregarded, since its pathogenicity for man is questionable.

M. intracellulare is occasionally found in the sputum of healthy, normal people. The first problem faced by the physician upon receipt of a re-

Unclassified mycobacteria will be reported by the Mississippi State Board of Health Laboratory according to species name instead of Runyon group numbers beginning January 1969. The author discusses the pathology sites and preferred form of treatment of the nontuberculosis mycobacteria which are potentially pathogenic. He notes that organisms that appear to be completely innocuous will still be reported as a Runyon group.

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port of these organisms in sputum is to try to determine whether or not the patient actually has disease caused by them. Several factors should be considered. X-ray evidence of disease; especially, progressive in type; and, whether there are repeated findings of the organisms in the sputum are most important. In patients who are not actually ill, it is advisable to take time to investigate the situation thoroughly before embarking on long, tiresome and expensive treatment. The organisms are not transmitted to contacts. If the patient is not actually having marked symptoms, it would be safe to wait to get another film after several weeks and have a number of sputum series run. Disease is usually found in middle-aged or elderly people. Ninety per cent of the cases of this disease admitted to Battey State Hospital in Rome (Ga.), were over 50 years of age. The youngest was 30 years old.

Mycobacterium intracellulare, unfortunately, is a difficult organism to treat due to the fact that it is naturally resistant to the ordinary antituberculosis drugs. It has been reported that when large groups of patients with lung disease due to these organisms are treated with drugs alone, the disease is inactivated and rendered bacteria free in only 22 per cent of cases. This percentage does not even approach the results with cases of "true" tuberculosis nor even those obtained in treatment of cases caused by *Mycobacterium kansasii* (Runyon Group I) with the common drugs.

DIFFICULTY IN TREATMENT

Both the diagnosis and treatment of disease due to this organism are complicated, tedious and prolonged. Actually, and unless a patient insists on treatment under the care of a private physician, everyone concerned would probably fare better if such cases were promptly sent to the Sanatorium, the VA Hospital or even put into the hands of the local health department. These agencies, especially the Sanatorium and VA Hospital, are well equipped and experienced in the treatment of this disorder.

Nevertheless, there will be individuals whom the physician will have to treat. A complete and timely discussion of the whole situation is given in an October, 1968, monograph: "Nontubercu-

NONTUBERCULOUS MYCOBACTERIA IN ORDER OF IMPORTANCE IN MISSISSIPPI

Name	*Runyon Group and Classification*	*Principal Pathology Site*	*Other Pathology Sites*	*Antituberculosis Drugs—INH, Strep., PAS*	*Preferred Form Treatment*	*Remarks*
M. avium M. intracellulare	III nonchromogens	Lungs	(all rare) cervical glands Osteomyelitis Kidney disease Disseminated disease with Meningitis.	Highly resistant. Drug therapy with regular drugs usually unsatisfactory. factory.	Institutional care. Drugs followed by surgery.	Most common in Miss. and southeast. Very difficult to treat. Organism common. Disease rare in proportion to commonness of organism. Old and middle-aged white men.
M. kansasii	I photochromogens	Lungs	(all rare) Bone Joint Genitourinary Peritoneum Disseminated disease with Meningitis.	Usually successfully treated by common drugs.	Institutional care. Drugs. Need for surgery becoming rare.	Seldom found in the southeastern states. Very similar to M. tuberculosis in many ways. Fairly easy to treat.
M. scrofulaceum	II scotochromogens	Cervical lymph nodes in young children	Pulmonary very rare	Highly resistant. Therapy with regular drugs usually unsatisfactory.	Excision of nodes indicated.	Common contaminate in sputum from T.B. cases as saprophyte. Often found in sputum of normal people.
M. fortuitum	IV rapid growers	Subcutaneous abscess	Pulmonary very rare.	Highly resistant. Therapy with regular drugs usually unsatisfactory.	Incision and drainage of abscess. Pul. disease may respond to Cloxacillin (Tegopen-Bristol) or other broad spectrum antibiotics.	Common in soil and water around the world. Common in sputum of T.B. cases as a saprophyte. Often found in sputum of normal people.
M. xenopei	III nonchromogen	Lungs Very rare in U.S.A.	Unknown	"Relative susceptibility to most antituberculosis drugs particularly Isoniazid."[2]	Antituberculosis drugs.	Organism common in Europe, disease caused by it rare. Organism and disease very rare in U.S.A.
M. marinum (balnei)	I photochromogen	Skin	None	Completely naturally resistant	Excision of lesion	The so-called "swimming pool granuloma." Rather uncommon.

lous Mycobacterial Disease" by K. H. Rfuetze and R. Hubble in DM-Disease a Month, Yearbook Medical Publishers, Inc., 35 E. Wacker Drive, Chicago, Illinois 60601. This has a splendid bibliography on the subject. Any physician interested in these diseases would profit greatly from this monograph.

Mycobacterium kansasii in Runyon Group I (photochromogens): This is being dealt with next, not because it is the next most frequent of these atypical organisms in Mississippi, but because it is the next in importance from the pathological standpoint in this area. It is rather rare in Mississippi but common in the Southwest and Middle West. Most cases have been reported from around Chicago, Dallas, Houston, and New Orleans. Those cases encountered by the Division of Tuberculosis Control in Mississippi, to a large extent, are referred to us from the Chicago area. Several cases have been found to have recently moved into the state from the endemic areas. Occasionally, a case turns up that apparently is of the "home grown" variety but it is rare.

This organism has been found to be present in two forms. These are distinguished by their reaction to the catalase test. The organism pathological for man shows a high catalase reaction. The low catalase variety is not usually pathogenic and if discovered will be reported simply as Runyon Group I (U.M.G. I) bacteria.

The high catalase form of *M. kansasii* is more similar to the tuberculosis organism in many ways than any of the other varieties of the atypical mycobacteria. Disease produced by it closely resembles tuberculosis clinically, radiologically and by favorable response to the common antituberculosis drugs. Around 80 per cent can be controlled by these drugs. As a disease, it shows a predilection for middle-aged and elderly men with chronic bronchitis and emphysema. The organism has occasionally been found in cervical lymph node disease in young children.

CHOICE OF CARE

As in the case of *M. intracellulare,* these cases are better treated by institutional care. When treated as a private case, it is suggested that ethambutol (Myambutol-Lederle) be considered. However, when this drug is used, careful attention should be given to its tendency toward eye complications. The drug should be given along with streptomycin and INH

M. scrofulaceum, in Runyon Group II (scotochromogens): This is the only pathogen being reported by name in Runyon Group II (scotochromogens). They are rarely found to be the cause of pulmonary disease in man. The scotochromogens (Runyon Group II) are the second most common organisms of the unclassified groups found in Mississippi. They are especially common contaminates in sputum of cases of "true" tuberculosis.

SINUS FORMATION

Cervical adenitis caused by *M. scrofulaceum* seems to have an unusual affinity for the submaxillary glands. Usually unilateral, it can produce a sinus formation.

All disease caused by these organisms is unsatisfactorily treated by the usual antituberculosis drugs. Resistance is almost complete. Localized lesions, such as lymph nodes, should be excised. Dissiminated disease (fortunately, extremely rare) is almost always fatal. All Runyon Group II organisms other than *M. scrofulaceum* will be reported as Group II organisms by the laboratory.

M. fortuitum, in Runyon Group IV (rapid growers): This is the only member of this rather large group of organisms that will be reported by name at the present time. It is widespread in nature and reported worldwide. Fairly common in sputum of normal individuals and in soil and water, it is found occasionally in patients with "true" tuberculosis as a contaminant and a harmless saprophyte. Few documented cases of pulmonary disease due to this organism have been reported. Some reports of subcutaneous abscesses have appeared in the literature; also, a few bone and endocardium.

Diagnosis, as well as treatment, is best accomplished at the Sanatorium. In the extremely rare case that requires treatment by the private physician, it would be best to have the organism tested for sensitivity to the antituberculosis drugs. One should also test the organism's sensitivity to many broad spectrum antibiotics. Successful treatment by cloxacillin (Tegopen-Bristol) in a case of pulmonary disease has been reported. Abscesses should be incised and drained.

It should be borne in mind that the finding of these organisms is, in itself, rather rare and, therefore, the number of cases that could be proven due to them would be rare enough to merit a report in the literature.

Mycobacterium (xenopei) in Runyon Group III (nonchromogens): Other than *M. avium-M. intracellulare* combination, this is the only other member of the nonchromogens that is found

to cause disease in the human. The organism was first cultured and identified eight years ago from the skin lesion of a South African toad encumbered with the name Xenopus laevis, hence the rather exotic name, *M. xenopei.*

Numerous cases of lung disease caused by it have been reported in Europe but, at present, it is extremely rare in the United States. In fact, it is so rare that it rates a report in the literature if discovered to be the agent in pulmonary disease. If it is found, it is more susceptible to the standard antituberculosis drugs than other members of the nonchromogen group.

M. marinum (M. balnei) in Runyon Group I (photochromogens): This is the last of the nontuberculosis mycobacteriae to be reported by name by the laboratory of the Mississippi State Board of Health. This organism is the cause of cutaneous lesions following abrasions of the skin on the walls of swimming pools. These "swimming pool granulomas" are best treated by excision due to the native resistance of the organisms to the usual antituberculosis drugs.

Several important facts should be borne in mind when dealing with nontuberculosis mycobacteria. To begin with, not every person having these organisms reported in the sputum has pulmonary disease caused by them. As a matter of fact, only a small percentage do.

As a usual thing, a patient has had to have some suspicious symptoms or the physician would not have sent in sputum specimens in the first place. Since all mycobacteria are acid fast, what steps should be taken by the physician when he receives a report of a sputum concentrate being found to contain acid fast organisms?

RADIOLOGIC DIAGNOSIS

First, of course, a chest film should be taken if one has not already been made. If such a film shows evidence of considerable infiltration, especially if in apex or subapical areas, one is justified in starting rest, isolation and at least INH and PAS immediately. The patient should be told, however, that no definite diagnosis has been made and the future treatment may have to be altered.

In patients with minimal x-ray changes, treatment can usually be delayed safely for three to four weeks while awaiting the report of the cultures. The patient should be told to "take it easy" during that time and to practice all precautions to protect those with whom he comes in contact. In both the above instances, a tuberculin test should be made. If the test is done with PPD-S and the resulting induration is over 10 mm. in diameter, one would probably be justified in starting, even the patient with minimal x-ray changes, on INH and PAS while awaiting the report of culture. Even moderately toxic symptoms should influence a physician to start the drugs promptly on receipt of a report of finding of acid fast organisms on concentrate.

OTHER MYCOBACTERIA

As time goes on, other mycobacteria of pathological significance will undoubtedly appear in addition to those listed at present. In case one appears on the laboratory report in the future that is not listed in this article, the necessary information in regard to it can be obtained by request from the Division of Tuberculosis Control, Mississippi State Board of Health, P.O. Box 1700, Jackson, Miss.

It should be remembered that it is not uncommon to find some of these organisms in sputum from cases suffering from "true" tuberculosis. Not infrequently the atypical organism will appear only in the first few sputum specimens, even in the presence of active tuberculosis. In these cases *M. tuberculosis* appears for the first time in specimens taken after the case has been under observation for several months. It is, therefore, important to continue to have repeat sputum examinations and to follow these atypical cases carefully for a long time.

In the last four and one-half years the laboratory of the Mississippi State Board of Health has found and reported 1,870 individuals harboring the unclassified mycobacteria. As a matter of interest, these cases were in the Runyon groups as follows: Group I (photochromogens)—20 cases, Group II (scotochromogens)—293 cases, Group III (nonchromogens)—1,534 cases, Group IV (rapid growers)—23 cases.

SUMMARY

All the nontuberculosis mycobacteria to be reported by the laboratory of the Mississippi State Board of Health by species name have been discussed.

1. It is better to take time to make a definite diagnosis before embarking on a long and expensive course of treatment.

2. Since there is no known danger, at present time, of transmitting the disease to contacts, the delay taken to confirm a diagnosis of pulmonary

disease caused by these organisms is well advised.

3. Since the pulmonary form of these diseases is usually chronic and slowly progressive, there is little danger to the patient of a few weeks' delay of treatment while confirming the diagnosis.

4. Only the organisms that are potentially pathogenic are to be reported by specific name by the laboratory. Those mycobacteria that experience has shown to be almost completely innocuous will still be reported as a Runyon Group. ★★★

State Board of Health (39205)

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SNELLEN SWINDLE

A young hippie was called up for his induction examination at the offices of his local draft board. Wishing to beat the draft, he deliberately flunked the eye test. He read everything wrong, claiming that he couldn't see and was promptly rejected.

Feeling good after he left the induction center, he treated himself to dinner in a restaurant and went to a movie. As he sat down in the theater, he was horrified to note that the man sitting next to him was the physician who had given him the pre-induction examination.

Thinking fast, he asked the doctor: "Pardon me, but does this bus go to Hackensack?"

—George Carlin *in Parade*

Radiologic Seminar LXXX: Traumatic Fat Embolism

JAMES M. PACKER, M.D.
Jackson, Mississippi

THE SYNDROME of fat embolism occurs after bone and soft tissue trauma which is usually severe in degree. The pathophysiological background for this condition is generally considered to be on the basis of intracellular fat being released into the extracellular space at the site of injury, following which free fat globules enter the venous circulation across damaged vascular walls. In the lesser circulation the larger particles occlude pulmonary capillaries and cause local tissue damage by a combination of resultant ischemia, altered blood viscosity, and direct toxic effect of hydrolized fatty acids on the alveoli. Smaller particles may pass through the pulmonary capillaries and become systemic emboli with involvement of the brain being the most important from the clinical point of view.

It is generally agreed that fat can be frequently identified in blood and multiple organs after trauma; yet the incidence of clinically significant fat embolization is thought to be quite low. In a large series of patients who sustained severe or multiple fractures and were treated at Massachusetts General Hospital, less than 1 per cent were found to show clinical or radiographic evidence of fatty emboli.

The onset of symptoms may occur at any time from a matter of hours to a period of several days after injury. Usually, the clinical picture reflects lung and brain involvement primarily. The symptoms and signs of pulmonary involvement are those one might anticipate with pulmonary embolization, the severity varying with the extent of involvement. Cough, dyspnea, tachypnea, and air hunger may appear suddenly. There may be a complaint of chest pain, and hemoptysis may occur although the latter is uncommon. On examination, a rapid weak pulse, rales, pleural rubs, and signs of circulatory collapse may be encountered.

In cases with brain involvement, focal signs and symptoms are unusual with there being more a picture of generalized vascular insult, headache, mental confusion, convulsions, stupor and coma found in varying degrees.

The finding of skin and conjunctival petechiae, ophthalmoscopic evidence of emboli in retinal vessels and lipuria, as detected by the laboratory, are other important indications of systemic fatty emboli. Identification of fat in the sputum and blood has been of limited clinical value.

Maruyama and Little, in a study of chest x-rays of cases of pulmonary fat embolism diagnosed at the Massachusetts General Hospital over a period of eight years, found several patterns of abnormality. Characteristically, the involvement was bilateral, resembling pulmonary edema with perihilar and lower lung field changes being the most obvious. The upper lung fields were generally clear, and the heart was usually not enlarged. Pleural effusion was not identified in their group of cases. Descriptive terms applied in describing findings on these different films included: pseudoplumonary edema, diffuse miliary mottling, clouding and patchy diffuse consolidation.

Radiographic clearing occurred over a period ranging from two days to two weeks, averaging one week. Out of the 10 cases studied in this series, there was only one fatality.

The accompanying x-rays are those of a 17-year-old white female who sustained severe fractures in an auto accident. Both pubic bones, the left ilium, both femurs and the right lateral malleolus were involved. An AP recumbent film of the chest was essentially clear on admission (see Figure 1).

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Hospital.

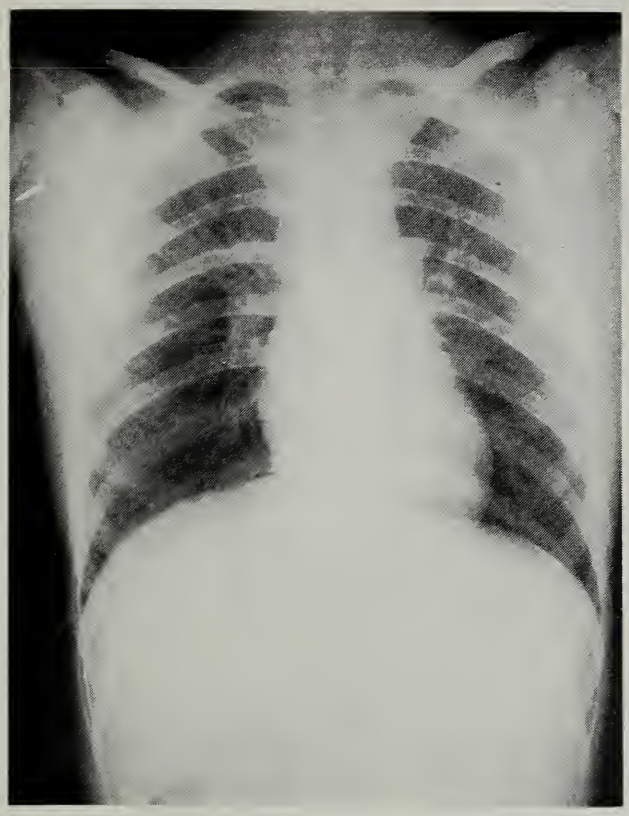


Figure 1. AP recumbent film of chest on admission with no significant abnormality being seen.

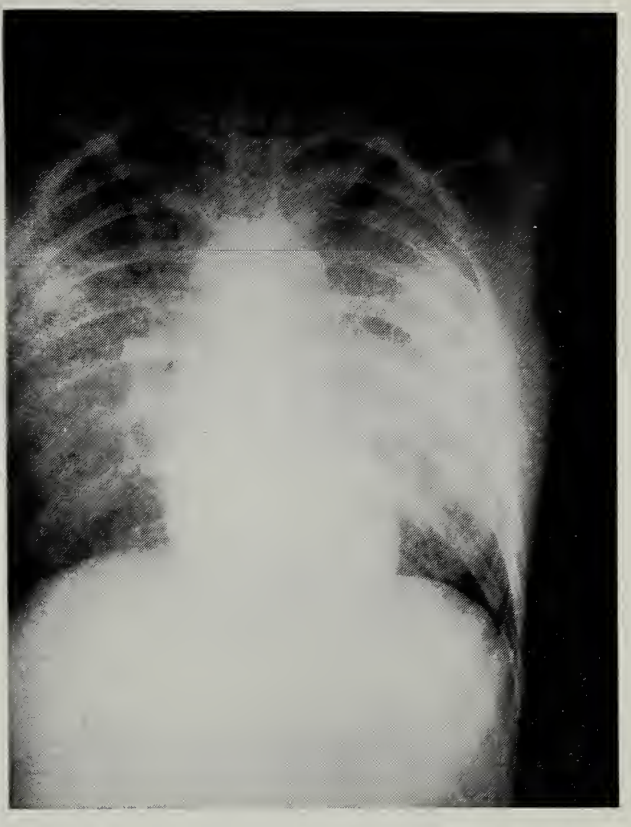


Figure 2. AP recumbent film of chest made by portable apparatus shortly after onset of acute respiratory symptoms. Note extensive confluent densities in both lung fields with sparing of the apices and bases. Cardiac shadow does not appear enlarged.

An intramedullary pin was placed in the left femur on the day of admission. Following this, the course was uneventful until the fifth day. At this time there was a sudden appearance of apprehension, restlessness, tachypnea, and tachycardia. A portable chest x-ray showed a widespread, hazy homogenous increase in density in both lung fields with the extreme apices and bases appearing relatively clear (Figure 2). The heart size was also noted to remain essentially normal. The diagnosis of fat embolism was suggested and confirmed by the finding of fat in the urine.

There was momentary improvement but 12 hours later acute dyspnea and tachycardia returned with death occurring shortly afterward. Autopsy showed extensive fatty emboli in the pulmonary capillaries and marked hemorrhage in the alveoli. Little abnormality was seen in the brain other than the presence of fat particles in the choroid plexus. ★★★

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A ROSE BY ANY OTHER . . .

The wife of a prominent businessman bought a new wig and thought it would be a good joke on her husband to surprise him at his office. Walking in, she said, "Do you think you might find a place in your organization for a woman like me?"

"Not a chance, lady," was the terse retort. "You look too much like my wife."

Diagnosis and Management Of Globus Hystericus

JOHN R. YOUNG, JR., M.D.
Natchez, Mississippi

PATIENTS FREQUENTLY PRESENT with the sole complaint of "Doctor, I have a lump in my throat," or even, "Doctor, my throat feels like it's tightening up." The patient is nearly always apprehensive, and upon further questioning, he states that he swallows frequently in an effort to get the lump down, but is never successful. After only a superficial evaluation, the diagnosis of globus hystericus is often applied.

The patient is told, "it's your nerves," and the clinician is lulled into a state of unjustified complacency. However, this complacency is rarely passed on to the patient, because he continues to notice the sensation of the lump in the throat. The symptoms may appear at any time and may last for minutes or hours and cannot be willed away. Symptoms may occur frequently for several days or weeks, may disappear for a time, and then without any apparent cause return months or even years later.

The patient is usually not able to localize the lump accurately and states that it may change slightly from time to time. It is usually worse when the patient is tired and most noticeable when the patient is swallowing saliva. There is usually no regurgitation and eating causes the sensation to disappear. The sensation of the lump in the throat is usually experienced in the hypopharynx or in the region of the cricoid.

The patient may complain of a tightness or constriction around the throat. Occasionally, patients will fear choking; however, most patients fear a malignancy. They have frequently been around or read of someone with cancer. Rarely some patients may complain of dysphagia, regurgitation, excessive mucus, hoarseness, stridor, foreign body, or cough. These are more important symptoms and usually alert the physician to a more serious organic problem. Occasionally, one may complain of hemoptysis or an inability to breathe through the nose.

In addition to a thorough history, all patients complaining of throat symptoms, however minor, should have a complete ENT examination with palpation of the neck. Mirror visualization of the nasopharynx and hypopharynx should rule out

The symptoms of globus hystericus may appear at any time, may last for minutes or hours and cannot be willed away. Differential diagnosis is considered in this paper and the author reviews the technique used in his practice to help patients accept the diagnosis of globus hystericus.

epiglottic cysts or benign or malignant neoplasm. A piriform sinus carcinoma can grow very large before any definite symptom, such as hoarseness or obstruction, develops, and quite frequently the initial complaints are only a vague fullness in the throat, at which time the doctor discovers the tumor and frequently an associated involved cervical lymph node. Vocal cord tumors usually produce hoarseness as the initial symptom. Occasionally, a large choanal polyp can extend into the oropharynx and produce a sensation of something in the throat. Any obstruction to nasal breathing will produce mouth breathing and associated dryness with chronic pharyngitis.

Palpation of the neck is extremely important. Presence of cervical nodes may eventually lead to a hidden primary lesion. Occasionally, a substernal thyroid will produce complaints relative to the throat, especially if there is pressure near the cricoid or upper trachea. Bimanual palpation of the mouth and tongue should be performed.

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DOW

Occasionally a carcinoma of the tongue will not be seen; however, it can produce symptoms and it can be readily felt with the bare finger. By grasping the larynx and moving slightly back and forth sideways, the physician will elicit the normal laryngeal crepitations; however, in laryngeal or esophageal neoplasms the laryngeal crepitations may be lost.

Usually, a thorough examination of the head and neck will fail to reveal any significant abnormality, and the diagnosis of globus hystericus is made. Patients with globus never have actual dysphagia; however, dysphagia will sooner or later be a major symptom in esophageal cancer. Cancer of the base of the tongue may simulate globus hystericus by the vague feelings of discomfort it produces. Patients with dentures should be examined closely for foreign body. Cervical arthritis and cervical spondylosis can mimic globus hystericus. Chronic laryngitis is aggravated by swallowing and is related to overuse of the larynx, particularly by excessive talking. However, as with globus hystericus, this is frequently worse at the end of the day when the patient is fatigued. Topical instillation of 2 per cent Tetracaine or 4 per cent Lidocaine to the larynx will relieve the discomfort caused by laryngeal irritation; however, this maneuver is apt to aggravate globus hystericus.[1] Rare Plummer-Vinson syndrome should be included in the differential diagnosis of globus hystericus.

ETIOLOGY OF SYMPTOMS

It is thought that the symptoms of globus hystericus are caused by increased tension of the cricopharyngeus muscle.[1] The lower horizontal fibers of the inferior constrictor muscle have been labeled the cricopharyngeus pinch-cock. The inferior constrictor is divided into the thyropharyngeus, which is attached to the oblique line of the thyroid cartilage, and the cricopharyngeus, which is attached to the lateral aspect of the cricoid. The constrictor muscles of the pharynx overlap each other like shingles of a roof inversely or like three flower pots which are sitting inside each other. The inferior constrictor overlaps the lower fibers of the middle constrictor and is probably the strongest of the three divisions. The annular fibers of the cricopharyngeus have a short total length as they course from the cartilage back to the cartilage around the entrance to the esophagus. This permits a mechanism for narrowing the lumen of the short horizontal fibers which contract to one-half their length. This sphincteric effect is enhanced by the immobility of the cartilage.

Increased tone of the horizontal fibers of the cricopharyngeus or failure to completely relax in response to contraction of the upper musculature is probably responsible for globus hystericus. Wallenborn feels there is a functional disturbance of the glossopharyngeal nerve with spasm of the pharyngeal muscle.[2]

MECHANISM OF SWALLOWING

The act of swallowing is complex. It requires muscular coordination that is easily deranged in emotionally upset persons. Discomfort may arise from excessive pressure on the esophagus by the rigid cricoid against the rigid spine.

Malcolmson feels that in some patients the symptoms of globus hystericus are produced by increased tone in the constrictor muscles of the pharynx, which may sometimes be due to everyday emotional reactions, such as sadness, grief, and anxiety.[3] Cancer phobia is definitely an aggravating factor.

However, he also found that many patients had unexpected organic lesions. This was particularly true when the sensation seemed unrelated to any obvious emotional disturbance and continued despite repeated and firm assurance that there was no underlying pathology. In 77 of the 231 patients that he reviewed, hiatus hernia was a coincidental finding. He suggested that the pharyngeal sensation may be referred through stimulation of afferent fibers in the vagus, with increased esophageal peristalsis. Patients with irritative lesions of the stomach and duodenum have increased esophageal peristalsis which may result in repeated dry swallowing which augments the arresting tone of the cricopharyngeus.

Although the careful physician usually satisfies himself that there is no serious organic disease and applies the diagnosis of globus hystericus to a number of patients who present with throat symptoms, it is usually more difficult to satisfy the patient that he has no organic disease. If the physician is unsure of his diagnosis or the patient is unduly apprehensive or does not seem to accept the diagnosis, an esophagram may be obtained. Usually the radiologist will report a normal esophagus; however, frequently the cricopharyngeal muscle will be found to produce a somewhat more prominent indentation than is usual. As stated above, occasionally a small unknown hiatus hernia will project above the level of the diaphragm and may initiate vagovagal reflexes resulting in globus symptoms.

It is our practice to take time to explain to the

patient the mechanism of his feeling of constriction or lump in the throat. We begin by showing a rough diagram of rings of muscles and explain the mechanism of the peristaltic wave; i.e. that the lower muscles should relax before the upper muscles contract to force the food downward. The patient is told that for some reason there is incoordination in his musculature and that his lower segments do not relax quickly enough and for this reason the upper segments must contract harder to squeeze any food or saliva down. We emphasize the fact that during emotional stress, fatigue or anxiety, muscles may spontaneously tighten.

Patients who we see have usually been told that the symptoms of globus are from nerves; however, a logical picture that they can understand has rarely been presented. Analogies such as the emotional control over vasodilatation during blushing are brought out to illustrate how the mind affects the various parts of the body. Other examples can be limitless, such as dryness of the mouth during fear or increased secretion of stomach acid in ulcer patients, and are readily understood by most patients.

The great majority of patients are helped by a simple explanation; however, a trial of medication is used in those who do not respond. The autonomic system is dualistic anatomically and antagonistic functionally. with the parasympathetic and sympathetic divisions serving nonstriated muscles, glands and organs not under voluntary control. Motor dysfunctions of the gastrointestinal tract may be caused by the functional lability of both autonomic divisions. In some individuals, one or more of these symptoms may predominate and in others both divisions of the autonomic system are overstimulated; therefore, it is not sufficient just to lower the tonus of the parasympathetic or the sympathetic, because this may lead to undue predominance of the other. It is well known that autonomic and endocrine reactions may result from psychological impulses; thus tension and emotional conflicts may interfere with smooth functioning of the autonomic control of the GI tract.[4]

A combination of ergotamine tartrate, which acts as a sympathetic inhibitor, levorotatory Belladonna alkaloids, which inhibit the parasympathetic, and phenobarbital (Bellergal Spacetabs), which acts as a sedative of the high centers of autonomic regulation in the hypothalamus is prescribed. Ergotamine and Belladonna inhibit adrenogenic and cholinergic impulses peripherally; that is, in the affector organs themselves. The central action of the phenobarbital potentiates these effects.

If a two-weeks' trial of Bellergal Spacetabs twice daily does not produce improvement in the patient's symptoms, a general tranquilizer, i.e., Meprobamate, Chlordiazepoxide—Librium (Roche), Hydroxyzine—Vistaril (Pfizer), may be instituted during stressful situations. It cannot be emphasized too highly that simply discussing rationally with the patient the hypothesis for the etiology of his complaints and stressing the fact that there is no malignancy history provides relief. In most patients anxieties are lessened and symptoms decreased but during periods of stress exacerbations occur, and there is need for some type of tranquilizers. We do not prescribe long-term tranquilizer therapy.

Esophagoscopy is undertaken only in extreme cases, when the physician is confronted with complaints of serious dysphagia, hematemesis, or abnormal esophagrams, or as a last resort in the extremely rare patient who persists in his complaints despite several examinations and assurances. ★★★

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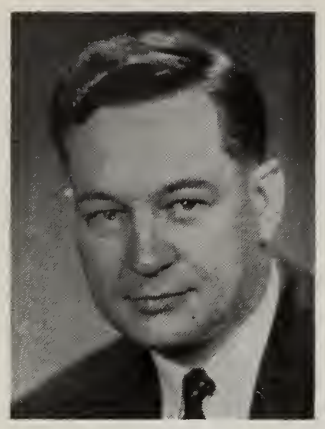
SCHWINN MILK?

Said the salesman to the farmer: "I'd like to sell you this bicycle."

"I'd rather buy a cow," the farmer replied.

"You'd look pretty silly trying to ride a cow."

"I'd look even sillier trying to milk a bicycle."



The President Speaking

'The 1969 Challenge'

JOSEPH B. ROGERS, M.D.
Oxford, Mississippi

If 1968 were a year of decision for Mississippi medicine, we can only surmise how monumental 1969 will be. In the year about concluded, the association has reached a new high in activities, in scientific work, in new areas of medical concern, and in facing crucial decisions. The signs for '69 say more and bigger, all straight ahead.

This year, we took bold steps in postgraduate medical education, publishing the most massive study ever undertaken by the association. Our scientific work was highlighted by an annual session built around live color television. The House of Delegates adopted a decisive course of action on voluntary prepayment, and we made a commitment to the concept of professional compensation by usual and customary fee. Our Board of Trustees, the eight councils, and the several committees are actively engaged in their respective areas of interest and responsibility.

The new year will be one of challenge, because our state must make a critical decision on Title XIX. The governor has stated that a special session of the Lesislature will be called for this purpose, and the entire health care team is seriously addressing its best efforts toward finding realistic solutions to problems implicit in program implementation. Our association is making a major study in this area, and our representatives are serving in key advisory capacities.

Challenge usually suggests change, and our task is to maintain the physician's voice in this process. It has been wisely said that he who ignores the challenge will not be a factor in the change. Our commitment is to meeting the challenge, and we possess a sound framework of policy within which to seek our goals. If every physician participates with serious concern, the challenge of 1969 will be met effectively, and the worthy goals we seek will be realized. ★★★

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EDITORIALS

Emergency Medical Services in Civil Disorders

I

Cities in flames, fired by rioters, casualties caused by snipers, and the wanton distruction of life and property are sad commentaries on the state of society in the richest, best educated, and most highly advanced nation on the planet. But wherever this abomitable destruction has occurred, physicians, hospitals, and members of the health care team have measured up to traditions of heroism in the care of all to whom injury has come. This is the story of Watts, Detroit, Cleveland, Newark, and the rest.

The physician, the police officer, the fireman, and many private and public service sources more often than not perform commendably in the face of insuperable difficulty, especially when rioters deliberately aim destruction at those whose purpose is the relief of suffering, restoration of order, and protection of life and property.

The American College of Surgeons has offered suggested guides for furnishing emergency medical services during civil disturbances which merit the careful attention and consideration of every local medical society. The guides call for support from civil authority for physicians and hospitals in carrying out their missions of mercy. This is a totally different kind of emergency service, scientifically and morally removed from the ravages of natural disaster. That injury and death from civil disturbance is inexcusably unnecessary isn't the central issue: The need for medical care has only the patient as the first consideration.

II

The College reminds us that communities in which destructive civil disorders occur usually have adequate warning. In almost every city where riots have taken place, the authorities were well aware of mounting tension, latent hostilities, and the potential of destruction. In sharp contrast, there is little warning against a major transportation disaster, a tornado, or mass food poisoning.

Additionally, casualties in natural disaster usually occur in a fleeting instant with little or no recurrence. Casualties in city riots tend to mount, reaching the highest and most dreadful proportion in the third of fourth day of the riot.

Studies by the ACS Committee on Trauma disclose that the most difficult problems faced by medical personnel and institutions are related to loss of telephone communications, inability of staff and allied professional personnel to reach the hospital, difficulty in communicating with families of riot victims and the press, lack of security and police protection, and problems of protecting or retaining prisoner patients.

Still other difficulties include a lack of proper identification for physicians and hospital per-

sonnel, shortages of vital medical supplies and food, and not least, the problem of caring for patients in non-riot emergencies.

When the city is aflame and the snipers are unchecked, everybody suffers.

III

The College recommends that within the community there first be a coordinated effort to meet riot emergencies among physicians and their component medical society, hospitals, and city government. An emergency medical service operations center should be established and oriented toward riot emergencies and how to cope with them.

Hospital reception centers are recommended, and heavy emphasis is placed on security in these centers. Controlled traffic routes, in-institution security, and protection for health team members outside the hospital are vital. A previously organized identification system for all medical personnel is necessary, and measures for continually re-supplying the hospital with drugs, food, and equipment should be effective.

The role of each hospital in the community should be carefully defined, including the areas of the city which it serves. In like manner, physicians would also have definite assignments and duty stations in periods of riot emergency.

IV

Within each hospital, according to the College's recommendations, security and communications come first. Wards nearest to the operating suites should be made available, and the emergency admitting and sorting service must be free of any interference.

Provision must be made for deployment, rotation, and quartering of personnel. A security ward for patients under arrest is necessary, suggesting a role for police within the hospital. It is obvious that visitors to a hospital must be restricted during riot emergencies, making an effective communications system all the more necessary for family notification.

Within the medical staff, the recommendations continue, there should be a briefing on principles to be utilized in caring for ambulatory patients and particularly for casualties with penetrating wounds. The physiological effects of gasses, such as CS, CN, and MACE, should be the subject of briefings for physicians.

Careful records must be maintained, even in the demanding crises of riot emergencies, and all missiles and foreign bodies removed in the care of wounds should be carefully preserved with appropriate patient identification. The staff will need special policies on use of drugs, antibiotics, tetanus prophylaxis, and shock treatment, and there must also be a plan for unexpected emergencies not related to the riot.

It is a big order, but planning for such an eventuality pays off. The main thing is to prepare and plan as physicians as we work as citizens dedicated to preserving law and order to make our plans unneeded.—R.B.K.

Rebel Gridders Have Medical Background

It's odds-on that even the most fervent and loyal Ole Miss supporter doesn't know that the last time the Rebels defeated the Alabama Crimson Tide before the 10 to 8 win this year, the team was coached by a physician. Moreover, one of the five surviving members of the 1910 victors, the center, is Dr. John C. "Red" Adams of Greenwood, an Emeritus member of the association and member of the Fifty Year Club.

Dr. Adams recalls the 16 to 0 shutout on a dismal Saturday in November, 1910, when the game was played at Greenville. There was no



"It's your turn to listen to my problems."

This "case history" runs to some 10,000 pages

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playing field as such; the officials roped off a cow pasture to keep the spectators off the field. He said that the attendance was about 375.

In 1910, there was no resident, full-time coach at the Oxford campus. A Philadelphia, Pa., physician, Dr. Nathan P. Stauffer, spent three months on the job each year, coming to Oxford on the day the team was scheduled to report and leaving for his practice on the day after the game with Mississippi A and M College, now Mississippi State University.

Dr. Stauffer was coach, team physician, athletic director, traveling secretary for the team, and "anything else that might come up," recalls Dr. Adams. Coach Stauffer ran his plays from a T-formation, but the quarterback usually stepped aside so that the center snapped the ball to any one of the three other backs who lined up five yards deep.

In those days, Dr. Adams says, the forward pass was not used, and a touchdown counted five points. A first down was made in five yards, but the team had only three tries for the yardage. Dr. Adams says that modern day football teams could make a shambles out of the Rebels of 1910. The mean weight was 170 pounds, and there were only 17 members of the squad. But this was a good showing, because Ole Miss was a "big" school with nearly 500 students.

Besides Dr. Adams, the surviving members of the 1910 Rebel squad are Kenneth Hoxton of Greenville, the quarterback; halfback Steve Mitchell, a Georgia attorney; and two Memphis attorneys, John McCall, another halfback, and Percy McDonald, the left end.

Dr. Adams praises Coach John Vaught as a superb coach, organizer, and recruiter. He notes that the SEC has come a long way since the days of the Southern Intercollegiate Athletic Association which was made up of Ole Miss, Alabama, Tulane, LSU, Tennessee, Auburn, Georgia, and Georgia Tech.

The history of medicine in Mississippi has been enriched by the contributions of physicians such as Dr. Adams.—R.B.K.

Last Call for AMA-ERF in 1968

Last call for contributions in 1968—and full deductions from 1968 taxes—for AMA-ERF. The current campaign, begun in October, will end with the calendar year. As in previous years, the response has been encouraging, giving evidence of the interest of physicians in the advancement of medical education.

AMA-ERF funds help medical schools in a unique manner. Unlike grant dollars which are limited and severely restricted, AMA-ERF dollars may be used in any manner the schools desire. The former dean of the University Medical Center and now director of the National Institutes of Health, Dr. Robert Q. Marston, often said that an AMA-ERF dollar was worth more than two of any other kind.

AMA-ERF funds underwrite loans to worthy students, interns, and residents. At our University Medical Center, a large number of eligible trainees have availed themselves of this financing method with which to further their medical education.

The association encourages every member to consider carefully the worth and merit of participation in AMA-ERF, the high return for investing in the profession's future, and the satisfaction of knowing that he has helped. And this is the last call for 1968.—R.B.K.

Chronicity and Impairment Among the Elderly

In the 1950's, one of the chief arguments by proponents of Medicare for the program was the fact that most individuals over age 65 had one or more chronic conditions. That chronicity should not be considered as carrying the same connotation as impairment was of little moment. Now, three years after Medicare, the facts and figures of reliable morbidity studies still show that the elderly, as a biological age group, are remarkably able physically and mentally.

Only one person out of six over age 65 is totally free of a chronic condition, but of those with such conditions, only one out of five is unable to carry on major activity. About a third of the senior citizens with a chronic condition experience no limitation of activity whatsoever.

As any physician knows, heart conditions most frequently impair activity in the elderly with arthritis and rheumatism coming in second. A range or orthopaedic conditions is third, visual impairment is fourth, and hypertension is fifth.

In the 45 to 64 age bracket, the picture is understandably better, but not in proportion to a score of years. About a third of the younger group has no chronic conditions, and half of them suffer no activity impairment. It is a fact, however, that the frequency of chronicity in the

older age group appears to be on the increase. On the other hand, the elderly incur fewer injuries requiring medical attention than their juniors.

Of this we may be sure: The advent of Medicare marked the beginning of higher utilization of hospital facilities by those over age 65. The impact of the program upon the general health status of the seniors remains to be demonstrated. —R.B.K.

Drivers: How Young and How Healthy?

One thing in Texas, in contradistinction to most everything else there, is small: The age of permanently licensed drivers. A 14 year old Texan is unique in that he may qualify for a full and unrestricted drivers license. Three states, Hawaii, Louisiana, and Mississippi, license 15 year olds.

The vast majority of the states, 36 to be exact, have set the minimum age at 16, while five states peg the age at 17 years and another five, at 18 years. Nebraska alone grants full and unrestricted operators licenses only to those attaining the legal majority of 21 years of age. This stiff requirement is softened with a sort of probationary arrangement for the licensing of minors between 16 and 20 years old.

In the past decade, American medicine has become deeply concerned over the vital medical considerations in the licensing of automobile drivers, and with good cause, too. A ton of metal, hurling down a highway at 70 miles an hour is a potentially fearfully destructive missile. The guidance system thus becomes crucially important.

It boils down to a relatively simple question: How young and how healthy should a driver be? The first part of the question is as controversial as the second. There are too many adults who are children behind the wheel, while some serious teenagers can demonstrate skill and proficiency in motor vehicle operation along with commendable maturity of judgment.

The state medical association's Committee on Medical Aspects of Driver Licensure has worked actively with the Mississippi Highway Safety Patrol in devising a medical examination procedure and developing a policy under which those who must be examined by a physician are seen privately under patrol supervision. Moreover, the physician is never called upon to say whether an applicant should be granted a drivers license; he merely reports his medical findings. The law charges the commissioner of the patrol with a final determination.

In the licensing of drivers, the law and pertinent medical aspects are closely related. Most state medical associations and the AMA have recognized this relationship, freely offering the services of multidisciplinary committees to advise state authorities. The age minimums for licensure are matters for state legislatures with due consideration for training programs. Where these pertinent factors are brought together in a perspective of reason, the carnage on the highway is probably reduced before the first engine is cranked up.—R.B.K.

POSTGRADUATE CALENDAR

CIRCUIT COURSES

SOUTHERN CIRCUIT

BILOXI—January 8, 15 and 22
Howard Memorial Hospital, 6:30 p.m.

HATTIESBURG—January 9, 16 and 23
Methodist Hospital, 6:30 p.m.
Session 1—Headache
Neurological Approach, Dr. Armin Haerer
Neurosurgical Approach, Dr. Robert Smith
Session 2—Cancer of the Cervix
Early Diagnosis, Dr. Karl Bolten
Current Practices in Management, Dr. Richard Boronow
Session 3—The Diagnosis of Cardiac Disease
In Children, Dr. David Watson
In Adults, Dr. Patrick Lehan

FUTURE CALENDAR

December 4, 1968

CHEST DISEASE SEMINAR

This postgraduate education course will deal with newer approaches to practical problems in respiratory disease. Guest lecturer will be Dr. Roger Mitchell, director of Pulmonary Diseases at the University of Colorado School of Medicine Department of Medicine.

January 13-17, 1969

STROKES AND RELATED NEUROLOGICAL DISEASES


Knee-deep

January 24, 1969

DERMATOLOGY SEMINAR

January 28, 1969

CIRCUIT COURSE, COLUMBUS

January 29-30, 1969

AUTOMATED ASSISTANCE FOR HEALTH CARE IN THE PHYSICIAN'S OFFICE

February 18, 1969

CIRCUIT COURSE, NATCHEZ

February 19, 1969

SYMPOSIUM ON HUMAN SEXUALITY

February 25, 1969

CIRCUIT COURSE, COLUMBUS

March 4, 1969

CIRCUIT COURSE, MERIDIAN

March 7, 1969

KIDNEY SEMINAR

March 17-20, 1969

STROKES AND RELATED NEUROLOGICAL DISEASES

March 26-28, 1969

CARDIOVASCULAR SEMINAR

April 1, 1969

CIRCUIT COURSE, MERIDIAN

April 15, 1969

CIRCUIT COURSE, NATCHEZ

April 22, 1969

CIRCUIT COURSE, COLUMBUS

May 6, 1969

CIRCUIT COURSE, MERIDIAN

May 12-15, 1969

MISSISSIPPI STATE MEDICAL ASSOCIATION

PERSONALS

A. V. BEACHAM of Jackson and Magnolia announced his resignation as director of the Alcohol Beverage Control Division of the State Tax Commission on Nov. 1. He had served in the key capacity since his appointment by former Gov. Paul B. Johnson in 1966 when the division was organized. Dr. Beacham, a former president of the Mississippi Hospital Association and former trustee of the state medical association, is currently chairman of the Council on Legislation. He also serves as vice chairman of the board of directors of the Mississippi Hospital and Medical Service.

THERESA L. R. BUCKLEY of Biloxi has been listed in the 1969 edition of *Who's Who Among American Women*. Dr. Buckley, the mother of two children, is active in Girl Scout work and local service and social organizations. A graduate of the Marquette University School of Medicine, she received her internship at St. Joseph Hospital at Milwaukee and her specialty training in ophthalmology at Milwaukee Children's Hospital and the Wood Veterans Administration Hospital. She is a member of the Coast Counties Medical Society, state association, and AMA, as well as various specialty societies.

CARLOS M. CHAVEZ, J. HAROLD CONN, WILLIAM R. FAIN, and LIDIO O. MORA of Jackson have been honored by the Angiology Research Foundation for their work in vascular medicine and surgery. They were recently presented with certificates of recognition by the foundation and an honors citation volume of the *Journal of Angiology*. Drs. Chavez and Mora have joint staff appointment at the V.A. Center and University Medical Center, and Drs. Conn and Fain are V.A. medical officers with appointments on the UMC clinical faculty.

BOYD C. EDWARDS and BEN B. JOHNSON of Jackson have been elected members of the American Society of Internal Medicine and its state component, the Mississippi Society of Internal Medicine. The society, a federation of 51 state components, studies the scientific, economic, social, and political aspects of medicine at state and national levels.

MARVIN V. HARVEY has announced the removal of his offices from McComb to North Cherry St. at Magnolia, effective Nov. 1.

VERNER S. HOLMES of McComb has been named chief of staff of the new Southwest Mississippi General Hospital, scheduled for opening next April. Other staff officers are RALPH L. BROCK, vice chief of staff; WILLIAM T. MAYER, secretary-treasurer; and FRANK L. BUTLER, JR., and JAMES M. BROCK, members of the executive committee, all of McComb. Dr. Holmes, a former president of the Board of Trustees of Institutions of Higher Learning of Mississippi, was recently reappointed to a 12 year term on the board by Gov. Williams.

LEWIS D. LIPSCOMB of Jackson has been assigned to the Air Force hospital at Tachikawa, Japan. The son of the late J. WALTON LIPSCOMB of Jackson, Dr. Lipscomb is a captain in the service. He completed his residency in obstetrics and gynecology at the University Medical Center immediately prior to entering the military service.

ESTELLE MAGERIA of Jackson has announced her affiliation with the Catholic Charities of Mississippi. She will provide specialized psychiatric services for clients of the Charities. Dr. Mageria retired last summer as director of Mental Health Services of the State Board of Health.

CHARLES A. MARASCALCO has returned to Vicksburg where he limits his practice to internal medicine and gastroenterology at Vicksburg Hospital. A graduate of the University Medical Center, he has completed his specialty training in the UMC Department of Medicine.

PAUL H. MOORE of Pascagoula served as state chairman of Doctors for Nixon during the recent presidential campaign. A graduate of UMC, Dr. Moore limits his practice to radiology. He is also a director of the American Cancer Society, Mississippi Division.

SAMUEL PHILLIPS, formerly of Memphis, has been appointed chief of staff at the Jackson Veterans Administration center, succeeding J. V. COCKRELL who recently retired. Dr. Phillips is a medical graduate of King's College Hospital School, London, and he received his postgraduate training at various New York hospitals. His primary field of interest is pulmonary disease, and he has been a medical officer with the Veterans Administration for 22 years.

NEW MEMBERS

The following physicians have been elected to membership by their respective component medical societies in the Mississippi State Medical Association and the American Medical Association.

BLAKEY, JOHN MALONEY, Tupelo. Born Detroit, Michigan, Feb. 15, 1937; M.D., University of Michigan Medical School Ann Arbor, 1963; interned William Beaumont Hospital, Royal Oak, Michigan, one year; radiology residency, Henry Ford Hospital, Detroit, Michigan, July 1, 1964-Feb. 1966; residency USPHS Hospital, Charity Hospital, New Orleans, Louisiana, Feb., 1966-May, 1968; elected Sept. 10, 1968, by Northeast Mississippi Medical Society.

HILL, JOHN EDWARD, Hollandale. Born Omaha, Nebraska, Feb. 2, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned U. S. Naval Hospital, Charleston, South Carolina, one year; elected Oct. 9, 1968, by Delta Medical Society.

JONES, ELBERT MARION, Meridian. Born Tiptonville, Tennessee, July 13, 1937; M.D., University of Tennessee College of Medicine, Memphis,



"Little Johnny Jones is here for his six months temper tantrum."

1962; interned University of Tennessee, Memphis, one year; obstetrics and gynecology residency, same, July 1, 1965-June 20, 1968; elected Oct. 1, 1968 by East Mississippi Medical Society.

O'Neal, Marcelene Jenkins, Greenville. Born Pontotoc, April 24, 1932; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned University Medical Center, Jackson, Mississippi, one year; pediatric residency same, July 1, 1966-June 30, 1968; elected Oct. 9, 1968 by Delta Medical Society.

Peeler, Joseph Glenn, Jr., Shaw. Born Cleveland, Mississippi, Feb. 12, 1941; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Lloyd Noland Hospital, Fairfield, Alabama, one year; elected Oct. 9, 1968 by Delta Medical Society.

Judicial Council Rules on Ethics

The Judicial Council of the Mississippi State Medical Association has issued opinions to update rulings in the area of medical ethics. The action came at the fall meeting of the elected body in which the judicial powers of the association are reposed.

Dr. Paul B. Brumby of Lexington, chairman of the nine member group, said that the council acted on organ transplantation, research involving human beings, drugs, treatment of obesity, laboratory services, professional fees, and bank credit card programs.

Members of the council are Drs. Rhea L. Wyatt of Holly Springs, Arthur E. Brown of Columbus, William B. Wiener of Jackson, Omar Simmons of Newton, J. P. Culpepper, Jr., of Hattiesburg, Leo J. Scanlon, Jr., of Natchez, James T. Thompson of Moss Point, Frank M. Acree of Greenville, and Dr. Brumby.

The council adopted the position that donors of vital organs such as hearts should be pronounced dead by a qualified physician other than the operating surgeon. The Declaration of Helsinki relating to care benefits and safeguarding in the course of research involving human beings was also adopted.

The council subscribed to an action by AMA in ruling that it is unethical for a physician to own shares in a drug repackaging company but that it is not unethical to own stock in a major pharmaceutical firm where the physician cannot and does not exercise control over the company or permit it to influence his choice of prescription drugs for his patients.

The council acted affirmatively to condemn the shotgun and usually simultaneous prescribing of cardiac glycosides, thyroid hormones, diuretics, anorexiants, barbiturates, amphetamines, and laxatives for the overweight. The council recognized that management of obesity is a difficult medical problem requiring the utmost in cooperation between patient and physician with full consideration for the individual patient's medical needs.

The condemnation of the so-called "rainbow pill" regimen underscored use of the cardiac glycosides and thyroid extracts.

Noting that the appeal of mail-order laboratories is primarily economic, the council took note of potential medicolegal complications where litigation might result. The physician, being liable for his diagnosis and treatment, should be able to summon his pathologist in such instances.

The council gave support to AMA positions on prohibition against charging interest on a professional fee or to make charges for arranging hospital admission, as opposed to the rendering of medical services.

The AMA position that it is ethical for physicians to participate in bank credit card programs where the patient freely and voluntarily elects to use this method of payment was supported. The council added "the patient who elects to use a bank card for payment of medical fees should be encouraged to pay on the first billing by the bank card service so as to avoid interest charges."

Dr. Brumby said that the Judicial Council would bring all such opinions to the House of Delegates in a formal report next year. The council also may serve as a trial body under stated judicial procedures. The recent meeting heard no such business, limiting its deliberations to matters of ethics.

Dr. Royals Addresses Nurses' Convention

Dr. James L. Royals of Jackson, president-elect of the state medical association, appeared as a speaker at the 14th Annual Convention of the Mississippi Federation of Licensed Practical Nurses. He stressed liaison between medicine and nursing, growing complexities in the clinical environment, mounting programs of care, and the knowledge explosion.

ORGANIZATION / Continued

He said that the need for close liaison between professional groups has never been greater. Pointing out that the nurse "stands closest to the physician in caring for the patient," he urged continued liaison between nursing and the state association through its Committee on Nursing.

Dr. Royals explained growing complexities in the clinical environment which can be traced to a host of rules and regulations with "vague delineations as to authority and responsibility." He also cited the growing number of public care programs and urged LPN's to fulfill postgraduate training challenges.

The convention was conducted at Jackson in early November.

MPHA Hosts Meet, Names New Leaders

Miss Cleta Brinson of Jackson was named for a full term as president of the Mississippi Public Health Association, having been serving on an interim basis since a special meeting earlier in the year. The administrative assistant at the State Board of Health assumed the high post at the conclusion of the fall convention of the association.

Roland B. Shows of Ellisville served as 1967-68 president. Mrs. Irene Loftus of Hattisburg was named president-elect. Convention registration hit about 700.

Appearing before a convention of MPHA for the first time since his appointment, Dr. Hugh B. Cottrell of Jackson, state health officer, was one of the principal speakers. Dr. Herbert A. Hudgins of Atlanta, associate regional director of the U.S. Public Health Service, was keynote speaker on the opening day of the conclave.



New MPHA officers are, seated, Miss Cleta Brinson, and standing from the left, Dr. James C. Totten, T. W. Williamson, and Dr. Steven L. Moore.

Dr. Alton B. Cobb of Jackson, director of the Division of Comprehensive Health Planning of the office of the governor, discussed the CHP program and the recently altered manner of USPHS making grants to states. He said that the new division has already begun its work with the granting of two research contracts.

Announcement was made last month that the Mississippi State Medical Association had contracted with the state through Dr. Cobb's office to perform a major research study in health information systems. A second contract with the Mississippi Hospital Association involves an inventory of hospital facilities and capabilities in the state.

Noble Swearingen of Washington, director the American Public Health Association blasted the Congress and HEW for "failing to keep faith with their state public health partners" by slashing Title XIX Medicaid funds. He warned that the program will be gutted or repealed in the 91st Congress.

The meeting was also addressed by Dr. William J. Brown of Atlanta, noted authority on venereal disease control who is associated with the National Communicable Disease Center.

A panel on family planning brought together a number of noted authorities, including Dr. Henry A. Thiede of Jackson, professor and chairman of ob-gyn at the University Medical Center, Dr. Ronald W. O'Conner of Atlanta, Georgia Department of Health, Mrs. Hazel Ann Hutcheson of Atlanta, a maternal health nurse consultant, and Mrs. Willetta Cahill, chief of maternity and infant care program at UMC at Jackson.

Other MPHA officers for 1968-69 include section chairmen. They are:

—Administrative: Dr. James C. Totten of Pascagoula, Jackson County health officer.

—Community Health Service: Harold H. Whitaker of Jackson, supervisor of the Health Insurance Unit at the State Board of Health.

DEATHS

No deaths of Mississippi physicians were reported to the JOURNAL during October, 1968.

Pharmaceutical Manufacturers Offer Reply to HEW Findings in Rx Drug Study

In a wide-ranging critique, the Pharmaceutical Manufacturers Association says the Second Interim Report of the HEW Task Force on Prescription Drugs has "contributed to confusion rather than enlightenment . . . by ranging too far afield from its main assignment."

PMA President C. Joseph Stetler charged that the Task Force relied "too heavily on second-hand, politically inspired sources of information as the . . . carefully selected witnesses before the Subcommittee hearings of Senator Kefauver and Senator Nelson."

The extensive PMA critique was recently submitted to Wilbur Cohen, Secretary of HEW.

In his covering letter, Stetler acknowledge the difficulty of the Task Force because of the "broad scope" of the subject and the "many divergent views held by the various individuals and groups concerned."

The Association strongly disagreed, however, with most of the conclusions reached by the Task Force, especially those dealing with drug prices, industry profits, promotion and marketing, research, patents, competition, and clinical equivalency.

On the other hand, PMA praised "the important and possibly original contributions" made by the Task Force survey of the health needs of the elderly.

"We have all been aware that this is a serious social problem involving grave hardship on people with limited income," the critique stated. "The industry is interested in exploring with other groups and government ways to meet this problem."

Some of the PMA comments from the covering letter and complete critique follow:

On Retail Prices

The Report cites "independent surveys" as "indices" for increases in drug prices. The PMA points out that these surveys, while indicating that the average expenditure per prescription has been increasing at a pace less than the general cost of living, this factor "is neither an appropriate scientific basis for comparison, nor is it identical with prices . . . and even less relevant to manufactures' prices."

The critique explained how Bureau of Labor Statistics "market basket" sampling and methods are valid and reflect the current selection of drugs.

On Generic vs. Brand Name Prices

The Task Force study described an average price of $2.02 for 30 generically prescribed products as against $4.11 for brand name products. The PMA questions whether this study has any meaning, since entirely different products were included in these averages, with the generic list consisting of older, less expensive products "whether prescribed by generic or brand names."

On Clinical Equivalency

"The Task Force should have explained that no two drug products are ever available from different manufacturers in identical dosage forms."

"Effects of formulation . . . cannot be separated from clinical effectiveness. Problems of formulation are extremely significant to the final clinical activity of a drug product. . . ."

"Most of the so-called 'chemical equivalents' purchased by leading American hospitals, the VA, the PHS, and the DOD are brand name products . . . from PMA member firms."

"There are no official standards for many very critical factors which affect clinical activity . . . and they cannot be used to determine quality. . . ."

"Assurance of drug quality depends upon the integrity and capability of the manufacturer. . . ."

On Research

"The Report shows a complete lack of under-

standing of the relative expenditures of funds and energies on various aspects of research . . . and of research competition."

"Except for the most successful products . . . without allowance for the funding of unsuccessful research, the estimate is not accurate." (This referred to the Report's assumption that a company will usually recoup its R&D costs three years after a product reaches the market.)

On Molecular Modification

"So-called molecular modifications have frequently achieved important advantages in increased effectiveness, potency, or reduced side effects."

On Combination Products

Contrary to assumptions in the Report, the PMA critique asserts that such products are generally less expensive than individual product elements taken separately, may provide therapeutic advantages, and certainly require less research than does the quest for single entity products.

On Marketing Expenditures

Here the PMA explains the fallacious figure of $600,000,000 (and the alleged $3,000 per doctor figure) that has frequently been cited as the cost of "promotion" annually. "Even if one were to accept this figure (which is actually closer to that for *all* expenses of distribution) as an estimate for the 100 companies engaged in an extensive range of marketing activities, it would result in an expenditure per company per doctor, dentist, and pharmacist of only $16 annually for both promotional and non-promotional activities. . . ."

On Profits

"In discussing profit differential, the Report completely ignores any other industry explanation except risk. It makes no mention of the correlation among industries between rates of return on investment and two other variables besides risk, namely, the rate of annual growth on product demand and the rate of research intensity. . . ."

On Competition

"The Task Force ignores the history of antibiotics, of steroids, and other therapeutic categories, where competition has resulted in both quality improvement and price reduction. . . ."

On Patents

"At a time when it costs about ten times as much as a decade ago to develop a marketable new product . . . (should a company) be deprived of the incentives . . . prescribed for inventors and innovators generally . . . ?"

On Physicians

"The Report is indefensibly pessimistic about the competence of practitioners of medicine . . . it notes that the doctor is faced with a great deal of advice, 'biased and unbiased' from commercial sources, and this is presumably true, but . . . a great deal of non-commercial advice, both biased and unbiased, also must be dealt with by the physician. . . ."

On an HEW "Medical Letter"

"What is needed is far from another publication by the government, but rather additional private mechanisms (or better organization of present ones) for the free communication of medical ideas."

On Foreign Operations

"The discussion of foreign prices . . . does not state that the vast majority of American prescription drug products sold abroad are manufactured abroad, where costs are generally cheaper. . . ."

Contrary to the Report's implications, "foreign nations generally impose fewer restrictions and less control on drug industries than in the United States. . . ."

On Drug Values

"A drug cost may go up but it may result in fewer visits to the physician, less hospitalization, or other increase in the efficiency of medical care that results in a net saving to the patient and/or the economy. . . ."

Association Sponsors Hawaii Jet Tour

A two-week, three-stop Hawaiian Carnival jet tour has been offered members of the Mississippi State Medical Association and their immediate families with a Feb. 10, 1969, departure date scheduled. The trip has association sponsorship.

Arranged by the American International Travel Service of Boston, one of the largest firms in the field, the tour will leave from Jackson's Allen Thompson Field by chartered jet on Feb. 10.

First stop will be Las Vegas, and after two days there, will fly nonstop to Honolulu.

Following more than a week in the island state, the trip will return for two days at San Francisco and then return to Jackson.

The $599 plus $19.50 tax and service total includes all air transportation by DC-8 fanjet, hotel accommodations, breakfasts and dinners, limousine and baggage transfers, sight-seeing, social and fellowship occasions, and other features. The tour returns on Feb. 24.

AITS spokesmen said that reservations will be made on a first-come, first-served basis, limited only by the passenger capacity of the aircraft and available luxury hotel accommodations. Informational brochures have been mailed to association members.

The Board of Trustees approved the trip for association sponsorship so as to take advantage of substantially lower travel rates for membership groups. The air travel component of the total cost is only $233, less than regular round trip fare to the West Coast.

Eighth MSMA-Robins Award Is Announced

The Eighth Annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1969 award will be presented at the 101st Annual Session during closing ceremonies on May 15.



MSMA-Robins Award

Dr. Joseph B. Rogers, president, and Dr. C. D. Taylor, Jr., chairman of the Board of Trustees, said that each component society had been invited to submit a nomination for the honor. The award is co-sponsored annually by the association and the A. H. Robins Co. of Richmond, Va., a long-established manufacturer of ethical pharmaceuticals.

Drs. Rogers and Taylor said that nominees must be members of the state medical association and that the community service recognized by the local society's nomination must be apart from purely professional attainment, since suitable awards in this connection already exist.

Generally, the service by the physician-nominee should have benefitted the local or state communities in a civic, cultural, or general economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in varying leadership roles.

Nominations should be made by letter, and there are no restrictions upon length or attached exhibits which assist in establishing the nominee's qualifications and record of achievement. Drs. Rogers and Taylor said that each letter of nomination must be signed by an officer of the component medical society.

Deadline for submission of nominations to the state medical association is Jan. 31, 1969. Each nomination will be acknowledged, and the Board of Judges, consisting of the three vice presidents, will review the nominations in February.

The award series was instituted in 1962, and seven Mississippi physicians have been recipients of the high honor. They are Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by the Northeast Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, by the Delta Medical Society in 1964; and Dr. Maura J. Mitchell, by the South Mississippi Medical Society in 1965.

Dr. J. T. Davis of Corinth, by the Northeast Mississippi Medical Society in 1966; Dr. Frank M. Acree of Greenville, by the Delta Medical Society in 1967; and Dr. W. H. Anderson of Booneville, by the Northeast Mississippi Medical Society in 1968.

The award is a sculptured bronze plaque in *bas* relief, engraved, and mounted on a mahogany panel.

St. Jude Opens New Retina Clinic

Opening of a retinoblastoma clinic for the diagnosis and treatment of tumors and other diseases of the retina in children has been announced by St. Jude's Children's Research Hospital at Memphis.

Information on the work of the clinic and arrangements for patients may be made through Dr. Charles B. Pratt or Dr. David Meyer at the hospital, the announcement said.

North Mississippi Elects New Leaders

Officers for 1968-69 were named by members of the North Mississippi Medical Society when annual elections were conducted at its recent meeting. The society includes Benton, Lafayette, Marshall, Panola, Tate, Tippah, Union, and Yalobusha counties.

Dr. George A. Brown of Water Valley was elected president, and Dr. Cherie Friedman of Oxford was named to another term as secretary-treasurer.

Vice presidents of the society are the alternate delegates to the state medical association from each county. Delegates and alternates include Drs. William L. Gray of Ashland, Vernon Harrison of University, C. M. Murry of Oxford, Herbert Phillips and Marion Greene of Holly Springs.

Also elected were Drs. George Carlson and John R. Lovelace of Batesville, John C. Powell and Mack Adams of Senatobia, and Ralph Ford and Tom Ketchum of Ripley.

Other delegates and alternates are Drs. E. E. Bramlitt and Jim Thornton of New Albany and George Brown and Dalton Spears of Walter Valley.

The society is the home component of Dr. Joseph B. Rogers, state association president, and Dr. James O. Gilmore, the District 2 Trustee, both of Oxford.

MAGP Conducts Meet, Names New Officers

The Mississippi Academy of General Practice inaugurated Dr. C. R. Jenkins of Laurel as its 1968-69 president at the close of the 20th Annual Assembly at Biloxi. Dr. Walter W. Crawford of Tylertown was named president-elect.

Dr. Joe E. Johnson of Mt. Olive served as 1967-68 president. Dr. William H. Parker of Heidelberg was elected secretary-treasurer, and Dr. John G. Atwood of Meridian was named vice president.

Also appearing on the program was Dr. George E. Burket of Kingman, Kansas, president of the American Academy of General Practice. The AAGP board chairman is a Mississippian, Dr. William E. Lotterhos of Jackson, and he participated in the meeting.

The three day assembly featured a range of scientific essays and technical and scientific exhibits. Recreational and social occasions included fishing, golf, and the annual party.

'Bama XIX Director Addresses Rotary

Dr. Thomas H. Alphin of Montgomery, Ala., director of the Alabama Title XIX program, was a special speaker at the Corinth Rotary Club last month. He warned that the hour was late for Mississippi to act on Medicaid, pointing out that Jan. 1, 1970, was the final cutoff date for federal health funds for states without a program.

Mississippi is one of 12 states without a Title XIX program, and at least four of these have developing programs with legislation already enacted.

Dr. Alphin was the guest of state Sen. Theodore Smith of Corinth. Dr. Frank M. Davis of Corinth was program chairman.

Dr. Alphin is a former director of the American Medical Association Washington Office. He left that post to become associate medical director of Equitable Life at the New York home office before accepting the appointment to head Alabama's Medicaid program.

Central Medical Expels Member

At its regular November meeting, the Central Medical Society voted to expel Dr. Robert P. Myers of Jackson from membership. The action came, an announcement said, after investigating certain charges and after admissions by Dr. Myers.

Within days of the formal action by the society, the Chancery Court of the 1st Judicial District of Hinds County granted a decree of supersedeas staying an order by the Mississippi State Board of Health which suspended Dr. Myers' license to practice in Mississippi. The Board of Health took action on Nov. 1, and the court granted the decree on Nov. 5, the same day the society acted.

The effect of expulsion from component medical society membership is to remove eligibility for state association and AMA membership.

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AAP Issues Guides on Athletics

The American Academy of Pediatrics has issued guidelines to govern the participation of elementary school children (boys and girls 13 years of age and younger), in competitive athletics.

The guidelines have been prepared as a joint statement by the AAP the American Medical Association's Committee on the Medical Aspects of Sports, the American Association for Health, Physical Education and Recreation, and the Society of State Directors of Health, Physical Education and Recreation.

The guidelines go on to point out that competitive sports, integrated into a sound physical education program, can direct funds, facilities, instruction and leadership toward all children in the school system or community.

"Such a program avoids providing a narrow sports experience for children, or one directed only to the physically gifted, the well-developed, the skillful, or the precocious children."

The guidelines also call for high-quality supervision, and for developing local community committees to formulate decisions about all school or community athletic programs. The committees should include education, recreation, and medical specialists.

The Academy, in its statement, urges that local decisions about athletic programs for children of elementary school age should consider the following:

—Proper physical conditioning.

—Conduct of the sport to include competent teaching and supervision, appropriate game equipment and facilities, and modification of rules.

—Careful grouping according to sex, weight, size, skill, and physical maturation when indicated.

—Good protective equipment, properly fitted.

—Well-maintained facilities suitable for the sport involved.

—Proper delineation of the spheres of authority and responsibility for school administration, family, sponsor, physician, coach, and athlete.

—Adequate medical care.

—Salient educational and recreational considerations. These should include daily physical education instruction for all children under the supervision of certified physical education teachers; opportunities for every child in the upper elementary grades to participate in an organized and supervised intramural athletic program, and assurance that the athletic program does not curtail the time or budget of the normal school program.

"Unless a school or community can provide exemplary supervision—medical and education—it should not undertake a program of competitive sports . . . at the preadolescent level," the joint statement concludes.

Central Backs Measles Shot Program

A public program offering immunization against measles, the Hinds County "Stop Measles" Sunday, was hailed a success. More than 1,500 children under age 12 received the immunization.

The project had the endorsement of the Central Medical Society and was actively sponsored by the Central Medical Auxiliary and the Hinds County Health Department.

Sixteen immunization stations were opened, and Jackson newspapers boosted the campaign with daily publicity and registration forms. In addition to Jackson, stations were open at Bolton, Edwards, Clinton, Raymond, Terry, and Utica.

Co-sponsoring organizations included the Kiwanis Clubs of Jackson, the Lions Clubs, Sertoma, Civitan, Hinds County P-TA Council, Hinds County Women's Civic Club, University Medical Center Wives Club, Pilot Club, Jaycees and Jaycettes, Quota Club, and Zonta International.

Prior to the Sunday campaign, Mayor Allen C. Thompson issued a "Stop Measles" proclamation.

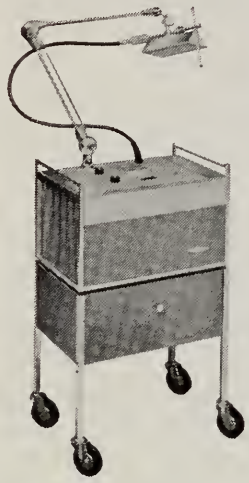
Mississippians Named to ACS Fellowship

Seven Mississippi surgeons were among more than 1,500 invested with fellowship at the recent clinical congress of the American College of Surgeons.

Named fellows of the College were Drs. Robert J. Cole of Amory, Hiram W. K. Batson of Brookhaven, Gilbert O. Spencer, Jr., of Columbus, Charlton R. Vincent of Laurel, and Allen U. Hollis, H. Richard Johnson, Jr., and James P. Spell of Jackson.

The degree, F.A.C.S., denoting fellowship, is awarded to candidates demonstrating acceptable attainment in medical education and postgraduate specialty work in addition to meeting ethical standards of the College.

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A thesis summary of 75 to 100 words must accompany each manuscript separately from the text. Figures and drawings are acceptable when prepared with black ink on white paper. Photographs for illustrations should be unmounted, untrimmed, glossy prints and all such material must be identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

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